



13768 Roswell Ave, Suite 221, Chino, CA 91710 Tel: (909) 548-6828 Fax: (909) 548-6893

**YOUR CHILD'S INFORMATION (ALL INFORMATION IS CONFIDENTIAL)**

Date \_\_\_\_\_ Child's Name \_\_\_\_\_ Nickname \_\_\_\_\_

Birthdate \_\_\_\_\_ Age \_\_\_\_\_ Child's School \_\_\_\_\_

Address \_\_\_\_\_

Phone \_\_\_\_\_ Child lives with  both parents  mother  father  other \_\_\_\_\_

Father's Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Mother's Name \_\_\_\_\_ Cell Phone \_\_\_\_\_

Emergency Contact (other than parents) Name \_\_\_\_\_ Phone \_\_\_\_\_

Name & Age of Brothers/Sisters \_\_\_\_\_

Who referred you to our office/How did you hear of our office?  
\_\_\_\_\_

**MEDICAL HISTORY**

Physician's Name \_\_\_\_\_ City \_\_\_\_\_ Phone \_\_\_\_\_

Last physical Checkup \_\_\_\_\_ Has patient ever been hospitalized? \_\_\_\_\_

When? \_\_\_\_\_ Reason \_\_\_\_\_

Is your child under medical care at the present? If yes, please state :  
\_\_\_\_\_

Does your child have any of the following?

- |                                      |   |  |  |  |
|--------------------------------------|---|--|--|--|
| <input type="checkbox"/> Anemia      | <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Unusual Bleeding        | <input type="checkbox"/> ADD/ADHD        |
| <input type="checkbox"/> Asthma      | <input type="checkbox"/> Heart Condition  | <input type="checkbox"/> Heart Murmur    | <input type="checkbox"/> Mental Retardation      | <input type="checkbox"/> HIV / AIDS      |
| <input type="checkbox"/> Hepatitis   | <input type="checkbox"/> Liver Conditions | <input type="checkbox"/> Autism          | <input type="checkbox"/> Blood Disorders         | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Convulsions | <input type="checkbox"/> Rheumatic Fever  | <input type="checkbox"/> Cerebral Palsy  | <input type="checkbox"/> Developmentally Delayed |  |
| <input type="checkbox"/> OTHER       | Please give details                       |  |  |  |

Medications taken  
\_\_\_\_\_

List all allergies to medications, food, substances, latex etc.  
\_\_\_\_\_

**DENTAL HISTORY**

Reason for visit (toothache, checkup, bad experience, emergency)  
\_\_\_\_\_

Is this the patient's first visit to the dentist?  YES  NO, If not, please provide previous dentist's name, address, telephone and what was done  
\_\_\_\_\_

Has your child :  Put to bed with bottle  injury to mouth or teeth  oral habits (thumb, pacifier, etc)

**FAMILY RECORD**

Residence Address \_\_\_\_\_ City, State, ZIP \_\_\_\_\_

Residence Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Father's full name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address if different \_\_\_\_\_

Occupation \_\_\_\_\_ Employed by \_\_\_\_\_

Mother's full name \_\_\_\_\_ Birthdate \_\_\_\_\_

Address if different \_\_\_\_\_

Occupation \_\_\_\_\_ Employed by \_\_\_\_\_

**GUARANTOR INFORMATION**

NO DENTAL INSURANCE

DENTAL INSURANCE, Please fill out below

Name of primary insured \_\_\_\_\_ Social Security No \_\_\_\_\_

Name of insurance \_\_\_\_\_ Group or Policy No. \_\_\_\_\_

Name of secondary insured \_\_\_\_\_ Social Security No \_\_\_\_\_

Name of insurance \_\_\_\_\_ Group or Policy No. \_\_\_\_\_

If family is not living together, person to be financially responsible for child's account

\_\_\_\_\_

**AUTHORIZATION / RELEASE AND INFORMED CONSENT**

I authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and /or other health practitioners. I authorize and request my insurance company to pay directly to the dentist/dental office, insurance benefits otherwise payable to me or to my dependents. I understand that any fee not covered by insurance is my responsibility, and understand that my insurance carrier may pay less than the actual bill for services. Payments/Co-payments or Deductibles are expected at time of service. Any balances over 60 days old, regardless of insurance involved will incur a 1.5% late payment charge. The office reserves the right to charge a cancellation fee for cancelled / broken appointments without a minimum 24 hours notice (Monday appointments must notify office prior to Friday)

Should there be any dispute or complication regarding dental treatment and management techniques (including sedation techniques). I agree to settle such claims through third party arbitration as my only remedy and agree to limit course of action to those recommended by third party arbitrator authority.

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. **It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dentist and the dental staff to perform any and all necessary dental treatment that my child may need, using treatment methods, medications and agents as they deem necessary in connection with his/her dental care.**

Date \_\_\_\_\_ Signature of Parent/Legal Guardian \_\_\_\_\_