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 of 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 _____

[] Doctor has reviewed medical history of child _____ Date _____
(dentist initials)

CHINO VALLEY PEDIATRIC DENTISTRY

FOR ALL CHILDREN, ADOLESCENTS AND SPECIAL NEEDS PATIENTS

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 the child ever been hospitalized? YES NO

When? _____ Reason _____

Is the child under medical care at present? YES NO If yes, please state:

_____

Does your child have any of the following? Please circle Yes (Y) or No (N)

Anemia	Y N	Diabetes	Y N	Fainting Spells	Y N	Unusual Bleeding	Y N
Asthma	Y N	Heart Condition	Y N	Heart Murmur	Y N	Mental Retardation	Y N
Hepatitis	Y N	Liver Condition	Y N	Autism	Y N	Blood Disorders	Y N
Convulsions	Y N	Rheumatic Fever	Y N	Cerebral Palsy	Y N	Develop Delayed	Y N
ADD/ADHD	Y N	HIV/AIDS	Y N	Kidney Problems	Y N		

Other (please give details) _____

Medications PRESENTLY being taken _____

List any allergies to medications / food allergies _____

Is the child allergic to latex ? YES NO Has your child taken diet drug Phen-Fen in past? YES NO

DENTAL HISTORY

Reason for this visit (toothache, checkup, bad experience with other Dentist, Emergency)

_____

Is this the patient's first visit to the dentist? YES NO

If no , please provide previous dentist's name, address, telephone and what was done

_____

Has your child been ? Put to bed with bottle YES NO Injuries to mouth / teeth YES NO

Oral Habits (Pacifer/Thumb) YES NO