WELCOME TO

WHERE TINY ADVENTURES BEGIN

PATIENT INFORMATION

Child's Name _____

Nickname _____ ○ Female ○ Male

Birthday _____ Age _____

School _____

Hobbies & Interests _____

Siblings (if any, names & ages) _____

Is Your Child Adopted? _____

How did you hear of us? _____

PARENT INFORMATION

Parents' Marital Status
○ Married ○ Divorced ○ Separated ○ Widowed ○ Single

Child Lives With
○ Both Parents ○ Parent 1 ○ Parent 2

Parent #1 Name _____

Relationship _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____

E-mail Address _____ E-mail ok? _____

Occupation _____

Employer _____ Work # _____

Parent #2 Name _____

Relationship _____

Address _____

City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____

E-mail Address _____ E-mail ok? _____

Occupation _____

Employer _____ Work # _____

Person other than guardians authorized to accompany child to their appointments:
Name _____ Relationship _____
Under no circumstances will your child receive any dental treatment without prior consent of guardians for (1) caretaker to accompany their child (2) signed treatment plan. Parents are responsible for informing us of alternative care ahead of the appointment. Initials _____

WHO IS ACCOMPANYING THE PATIENT TODAY?

Name _____

Relationship _____

Do you have legal custody of this child? _____

PERSON RESPONSIBLE FOR ACCOUNT

Name _____ Relationship _____

For Appointment Confirmations:

Primary Number _____

Cell Phone Consent: "I consent to the dental practice using my cell phone number to (choose one or both) CALL or TEXT regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time." Initials _____

Telephone Message Consent: "I understand brief messages from the dental practice may be left on my home/cell phone or with anyone who answers the telephone at my home unless I have provided the practice with alternative instructions for communication." Initials _____

PRIMARY INSURANCE

Insurance Co. _____

Insurance Co. Phone Number _____

Name of Insured _____

Insured Birthdate _____ Insured SSN _____

Group/Policy # _____

Employer _____

SECONDARY INSURANCE

Insurance Co. _____

Insurance Co. Phone Number _____

Name of Insured _____

Insured Birthdate _____ Insured SSN _____

Group/Policy # _____

Employer _____

I hereby authorize payment directly to Burlingame Pediatric Dentistry of the group insurance benefits otherwise payable to me. I understand that responsibility for payment of services provided in this office is mine, regardless of insurance involvement. Your payment is required at the time of service and is collected from the guardian who brings the child in for the dental services unless prior arrangements are made.

Responsible Party _____ Date _____

DENTAL HISTORY

Reason for Today's Visit _____

1st Dentist Visit? ○Y ○N Previous Dentist _____

Date of Last Visit _____ Date of Last X-rays _____

How may we help make this visit a positive experience for your child?

_____

Has your child experienced any injuries to the teeth, mouth, or jaws OR pain, tenderness, or noise in either jaw?

_____

Has your child ever had an unfavorable reaction after dental treatment?

_____

Does your child have any of the following habits?

☐Breast Feeding-Until Age _____ ☐Bottle Feeding-Until Age _____

☐Suck Fingers-Until Age _____ ☐Pacifier Use-Until Age _____

☐Suck/Bite Lips ☐Bite/Chew Nails

☐Clench/Grind teeth ☐Snoring/Mouth Breather

How many times a day are your child's teeth brushed? ☐1 ☐2

Brushing with Fluoride toothpaste? ☐Y ☐N

Does your child floss his/her teeth daily? ☐Y ☐N

Do you brush/floss your child's teeth for them? ☐Y ☐N

Does your child take gummy vitamins? ☐Y ☐N

How many snacks between meals per day? _____

How many times a day does your child drink milk, juice, or sweetened beverages outside of meals? _____

CHILD'S PHYSICIAN & HEALTH HISTORY

Name of Physician _____

Address _____

Phone _____ Date of Last Visit _____

Is your child under the care of a medical specialist? ○Y ○N

Name & Type of Specialist _____

Reason for Specialist _____

Are Immunizations Current? ○Y ○N

Does the child pre-medicate with antibiotics prior to dental appointments? ○Y ○N

Is your child on a special diet? ○Y ○N

Is your child having difficulties in school? ○Y ○N

MEDICAL HISTORY

Has your child been diagnosed and/or treated for any of the following?

AIDS/HIV Positive/or any immune Disorder	☐Y	☐N
Blood disorder/Abnormal Bleeding	☐Y	☐N
Anxiety/Depression	☐Y	☐N
Artificial Joints/Valves	☐Y	☐N
Asthma/Reactive Airway Disease	☐Y	☐N
Autism/ASD/Sensory Disorder	☐Y	☐N
Behavioral/Learning Challenge /ADHD	☐Y	☐N
Bone/Joint Problems	☐Y	☐N
Cancer/Tumor/Leukemia	☐Y	☐N
Cleft Lip/Palate	☐Y	☐N
Developmental Delay	☐Y	☐N
Diabetes	☐Y	☐N
Epilepsy/Seizures/Convulsions/Fainting Spells/Dizziness	☐Y	☐N
Frequent Ear/Sinus Infections	☐Y	☐N
Handicaps/Disabilities/Special Needs	☐Y	☐N
Hearing/Speech Issues	☐Y	☐N
Heart Conditions	☐Y	☐N
Hives or Rash	☐Y	☐N
Kidney/Liver Problems	☐Y	☐N
Rheumatic/Scarlet Fever	☐Y	☐N
Seasonal Allergies/Hay Fever	☐Y	☐N
Stomach/GI Disorders	☐Y	☐N
Thyroid Disease	☐Y	☐N
Tuberculosis	☐Y	☐N
Vision Impairment	☐Y	☐N

Does the child have a history of the following?
☐Premature Birth ☐Serious Illness ☐Hospitalization/Operation
☐Allergies to Medications ☐Food Allergies ☐Latex Allergy

List of Allergies _____

Current Medications _____

✖ Does your child have any other disease, condition or syndromes not listed above?

_____

✖ Is there anything else regarding your child's physical, mental, or emotional health that we should know about your child or would like to discuss in private?

_____

Our office is committed to the highest standards of infection control mandated by OSHA, CDC, and ADA. I understand the information I have given is true and correct to the best of my knowledge, that it will be held in the strictest of confidence. I grant this office permission to provide my child's dental treatment as deemed necessary, utilizing proper and acceptable methods used in the specialty of pediatric dentistry to complete treatment, including diagnostic radiographs and fluoride treatment and communicating with other healthcare providers involved in your child's treatment. I understand it is my responsibility to inform the office of any changes in my child's health or medications.

Name of Parent or Guardian _____ Signature _____ Date _____

Doctor's Signature _____ Date _____