The Children's Dental SPECIALIST
"WHERE THE SEEDS OF GOOD ORAL HEALTH ARE PLANTED"

The Children's Dental Specialist Southbay
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New Patient Form

Today's Date:

NOTE: The parent or guardian who accompanies the child is responsible for payment at the time of service.

1. TELL US ABOUT YOUR CHILD

Child's Name: _____
Last First Middle

Goes by: _____ ☐ Male ☐ Female

Siblings that we treat: _____

Child's Birthdate: _____/_____/_____ Child's Age: _____

School: _____

Child's Home #: (____) _____

SSN: _____

Child's Home Address: _____

_____
City State Zip

2. MOTHER'S INFORMATION

Name: _____

Mother Stepmother Guardian Birthdate: _____/_____/_____

Address: _____

_____
City State Zip

Employer: _____

Work #: (____) _____

Home #: (____) _____

Cell #: (____) _____

SSN: _____ DL#: _____

Email Address: _____

3. FATHER'S INFORMATION

Name: _____

Father Stepfather Guardian Birthdate: _____/_____/_____

Address: _____

_____
City State Zip

Employer: _____

Work #: (____) _____

Home #: (____) _____

Cell #: (____) _____

SSN: _____ DL#: _____

Email Address: _____

4. WHO MAY WE THANK FOR REFERRING YOU?

_____

5. WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____

Relationship: _____

Do you have legal custody of this child? ☐ Yes ☐ No

6. PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

Relationship: _____

Billing Address: _____

_____
City State Zip

Employer: _____

Work #: (____) _____

Home #: (____) _____

Cell #: (____) _____

Email Address: _____

7. PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____/_____/_____

SSN: _____

Policy Owner's Employer: _____

8. SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____/_____/_____

SSN: _____

Policy Owner's Employer: _____

9. DENTAL HISTORY

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Previous dentist's name: _____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain: _____

_____

Why did you bring your child to the dentist today? _____

_____

_____

Does the child have any of the following habits?

Y N Lip Sucking / Biting Y N Nail Biting

Y N Nursing / Bottle Habits Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? YES NO

If yes, please explain: _____

_____

Is the child's water fluoridated? YES NO

Is the child taking fluoride supplements? YES NO

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)? YES NO

Does the child brush his/her teeth daily? YES NO

Floss his/her teeth daily? YES NO

10. HEALTH HISTORY

Has the child ever had any of the following conditions?

Y	N	Autism/Learning Disabilities	Y	N	Handicaps/Disabilities
Y	N	Allergies to any Drugs	Y	N	Hearing Impairment
Y	N	Any Hospital Stays	Y	N	Heart Disease/Murmur
Y	N	Any Operations	Y	N	Hepatitis
Y	N	Asthma	Y	N	HIV + / AIDS
Y	N	Cancer	Y	N	Kidney/Liver Conditions
Y	N	Congenital Birth Defects	Y	N	Rheumatic/Scarlet Fever
Y	N	Convulsions/Epilepsy	Y	N	Allergies to Latex Product
Y	N	Pregnancy	Y	N	Diabetes
Y	N	Tuberculosis	Y	N	Hemophilia/Blood Disorders
Y	N	ADD/ADHD	Y	N	Reflux/GI Problems
Y	N	Osteoporosis/Bone Diseases			

Please discuss any serious Medical Conditions the child has had:

_____

_____

_____

_____

Please list all the drugs the child is currently taking: _____

_____

_____

_____

Please list all drugs the child is allergic to: _____

_____

_____

Child's Physician: _____

Phone #: (____) _____

Is the child currently under the care of a physician? YES NO

Please describe the child's current physical health:

GOOD FAIR POOR

CANCELLATION POLICY IS AS FOLLOWS:

I acknowledge that appointments without 48 hours notice of cancellation by patient/parent will result in a $75.00 cancellation fee. _____ (initial)

HIPAA Notice of Privacy Practices posted and available (additional copies available upon request) _____ (initial)

A law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals and other health care providers.

I authorize the dental staff to perform the necessary dental services my child may need. X-rays (_), Exam (_), Cleaning (_), Fluoride Treatment (_)

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

_____ _____

Signature of Parent or Guardian Date Relationship to Patient

FOR OFFICE USE ONLY

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials _____ Date _____

Doctor's Comments:

_____