Redwood City Pediatric Dentistry

51 Renato Ct. Ste. B, Redwood City, CA 94061
T 650.365.3430

Child's name: _____ Nickname: _____ Sex: (M) (F) Birthdate: _____

Purpose of visit: _____ Concerns:_____

Name and age of brothers/sisters: _____ Is your child adopted? Y N

Child's Interests: _____ Name of Pet(s):_____

Does your child have any special needs? _____ Any phobias? _____

Child's learning: slow __average __accelerated __Child's school: _____

Who may we thank for referring you to us? _____

Health History

Child's Pediatrician: _____ Phone number :_____ Last Physical: _____

Pediatrician's address _____

Is your child under a physician's care now? Y N If yes, reason: _____ Immunization up to date? Y N

Is your child taking any medications currently (including over the counter)? Y N If yes, please list:_____

Is your child allergic to any medication? Y N If yes, please list: _____

Does your child have allergic reaction to: food(s) ___ animals____ pollen____ dust____ latex____ eggs____ other_____?

Has your child had a history or difficulty with any of the following?

TMJ problems	Y	N	Premature Birth	Y	N	Speech Disorder	Y	N
Diabetes	Y	N	Bleeding	Y	N	Sinus Problems	Y	N
Allergies to Medications	Y	N	Brain Injury	Y	N	Earaches/Infections	Y	N
Liver/Jaundice	Y	N	Hepatitis	Y	N	Tuberculosis	Y	N
Heart	Y	N	Immune Disorders	Y	N	Bruising	Y	N
Rheumatic Fever	Y	N	ADHD/ADD	Y	N	Cancer/Malignancies	Y	N
Seizures	Y	N	Autism	Y	N	Down's Syndrome	Y	N
Depression/Anxiety	Y	N	Arthritis	Y	N	Kidney	Y	N
Cerebral Palsy	Y	N	Delayed Development	Y	N	Hearing	Y	N
Bladder	Y	N	Bone Disorder	Y	N	Nosebleeds	Y	N
Asthma	Y	N	Eating Disorder	Y	N	Emotional/School Problems	Y	N
Last Asthma attack: _____			Tooth or gum pain	Y	N	Other: _____		

If Yes, please explain: _____

Dental History

Is this your child's first dental visit? Y N If no, previous dentist: _____ Phone number:_____ _____

Date of last visit: _____ How was his/her experience? _____ Were any x-rays taken? Y N

Child's attitude towards the dentist or dental care: _____

Has your child had any injuries to teeth, mouth, or head? Y N If yes, please describe: _____

Does your child have any of the following habits?

Please circle: thumb/finger pacifier nail biting lip sucking mouth-breathing snoring teeth grinding nursing bottle-feeding

Is your water fluoridated? Y N Does your child take fluoride supplements? Y N Does your child use fluoridated toothpaste? Y N

How often does your child brush his/her teeth? _____ With adult supervision? Y N How often does your child floss? _____

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

Please continue to the back side…

General Information

Father (full name) _____ SSN: _____ Birthdate: _____ Driver's License #:_____

Mother (full name) _____ SSN:_____ Birthdate: _____ Driver's License #:_____

Parent(s) are: Married ___ Divorced ___ Single ___ Widowed ___ Partners ___ Child lives with: both parents mother father legal guardian

Person financially responsible for child's dental care:_____

Home Address: _____ Home Phone:_____

Father's Employer: _____ Occupation:_____ Cell Phone:_____

Business Address: _____ Email:_____ Text OK?: Y N

Mother's Employer: _____ Occupation:_____ Cell Phone: _____

Business Address: _____ Email:_____ Text OK?: Y N

Emergency Contact: _____ Relationship: _____ Home Phone:_____ Cell Phone: _____

I hereby give Redwood City Pediatric Dentistry permission to complete an oral exam and radiographs (x-rays) for diagnostic purposes. I understand this visit will include a cleaning and fluoride treatment as well. 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 the office of any changes in my child's health status.

SIGNATURE:_____ Relationship:_____ Date:_____

Insurance Information

Do you have dental insurance coverage for your child? Y N

Father's Insurance Company: _____ Insurance ID#:_____

Father's Insurance Company Phone: _____ Group or Policy Number: _____

Address of Father's Insurance Company: _____

Mother's Insurance Company: _____ Insurance ID#: _____

Mother's Insurance Company Phone: _____ Group or Policy Number: _____

Address of Mother's Insurance Company: _____

I hereby authorize the dentist to release any information including diagnosis and records to the third party payer and/or other health care practitioners. I authorize and request my insurance to pay directly to the above named dentist, otherwise payable to me but not to exceed the charges shown on the claim. This office is not responsible for any insurance company's arbitrary determination of payment, which procedures are covered under the plan, frequency of procedures performed, or period of time taken to process claims. You are responsible for payment in full regardless of any insurance you may have. As a courtesy to you, we will complete and file insurance forms relative to dental treatment and will do our best to collect all fees due from your insurance carrier. However, fees not paid by your insurance company within 60 days are due and payable by the patient's parent or guardian. I realize that the failure to keep this account current may result in the dentist being unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. I understand a late charge of 1.5% per month will be applied to unpaid balances over 30 days past due and where appropriate, a credit bureau report may be obtained. In case of default on payment of this account, I agree to pay the collection costs and reasonable attorney fees incurred in attempting to collect on this account of any future outstanding account balances.

Responsible party policy:

Because of a large percent of the population involves a divorce situation, it is the policy of this office to collect from the parent who brings the child in for dental services.

Office policies:

Unless appointments are cancelled at least 48 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. We do attempt to confirm appointments, but do so only as a courtesy. The Parent/Guardian is ultimately responsible for any scheduled appointments made for the child.

I acknowledge that I have read and agreed to the above policies.

SIGNATURE:_____ Relationship: _____ Date:_____

Acknowledgment of receipt of NOTICE OF PRIVACY PRACTICES (HIPAA)

You may refuse to sign this portion of the acknowledgment

I, _____have received a copy of or have had the opportunity to review this office's NOTICE OF PRIVACY PRACTICES (HIPAA).

SIGNATURE:_____ Print Name:_____ Date:_____