Antioch Brentwood Pediatric Dentistry

THE INFORMATION YOU INCLUDE ENABLES US TO PROVIDE BETTER CARE FOR YOUR CHILD

Child's name _____ Nickname _____
First Middle Last

Sex: M ___ F ___ Birthdate _____ Adoption or guardianship _____

What is the reason for this visit? _____

Is this your child's first dental visit? _____ Date of last visit? _____ Purpose _____

What was your child's attitude towards previous dental care? _____

Have we seen other children in your family? _____

Name and age of brothers and sisters _____

Name of child's pet _____ Child's interests _____

Name of family dentist _____ Child's previous dentist _____

Who may we thank for referring you to our office? _____

MEDICAL INFORMATION

Child's pediatrician _____ Phone number _____

Date of last physical exam _____ Is your child under a doctor's care now? _____

For what reason? _____

Is your child taking any medication or drugs? _____ Please list: _____

For what reason? _____

Has your child ever been hospitalized? _____ When? _____

For what reason? _____

Is your child allergic to any medications? _____ Please list: _____

Describe the reaction _____

Does your child have an allergic reaction to food? _____ animals? _____ pollen? _____ dust? _____ latex? _____

Does your child have good physical co-ordination? _____

Are your child's immunizations up-to-date? _____

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

YES	NO		YES	NO		YES	NO	
___	___	Allergies to Medication	___	___	Bleeding Problems	___	___	Hearing Difficulties
___	___	Premature Birth	___	___	Nosebleeds	___	___	Earaches
___	___	First Year of Life	___	___	Bruising	___	___	Gag Reflex
___	___	Heart Problems	___	___	Anemia	___	___	Motion Sickness
___	___	Rheumatic Fever	___	___	Hepatitis	___	___	Cancer or Malignancies
___	___	Asthma	___	___	Brain Injury	___	___	Kidney Problems
___	___	Seizures	___	___	Cerebral Palsy	___	___	Fainting or Dizziness
___	___	Diabetes	___	___	Bone Disorder	___	___	Speech Disorder
___	___	Immune Disorder / HIV / AIDS	___	___	Liver Problems	___	___	Reflux or Regurgitation
___	___	Tuberculosis	___	___	Delayed Development	___	___	Eczema

Comments/Details _____

_____ Reviewed History:

Does your child have any phobias? _____ Any emotional or school problems? _____

How would you describe your child's learning: Slow _____ Average _____ Accelerated _____

To the best of my knowledge the above information is true. **Signature**_____ **Date**_____

Leslie Tanimura, DDS, MSD • Jennifer Lo, DMD, MS • Richard Sobel, DDS

DENTAL INFORMATION

Was your child bottle fed? _____ Until what age? _____ Breast fed? _____ Until what age? _____

Does your child have any mouth habits such as: Finger/thumb sucking _____ Tooth grinding _____

Lip sucking _____ Mouth breathing _____ Pacifier _____ Nail biting _____ Other_____

Has your child ever had any injuries to his/her teeth, mouth or head? _____

If yes, please describe _____

Has your child taken fluoride? _____ In what form and when? _____

Does your child brush regularly? _____ Does an adult assist with brushing? _____

Does your child use dental floss? _____ Does an adult assist with flossing? _____

Has either parent or child been treated orthodontically? _____

How do you expect your child to behave in our office? _____

Describe your child: Outgoing_____ Shy_____ Stubborn_____ Anxious_____ Frightened_____ Regular kid _____

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

_____

_____

GENERAL INFORMATION

This information is requested for financial and credit purposes.

Name of person who is financially responsible for this child _____

FATHER (full name) _____ Date of birth _____ Marital status _____

Home address _____ City/State _____ Zip _____ Home phone _____

Employer _____ Address _____ City _____ Work phone _____

Social security number _____ Driver's license number _____

Email _____

MOTHER (full name) _____ Date of birth _____ Marital status _____

Home address _____ City/State _____ Zip _____ Home phone _____

Employer _____ Address _____ City _____ Work phone _____

Social security number _____ Driver's license number _____

Email_____

Child resides with: Both parents_____ Mother_____ Father_____ Other_____

Name of nearest relative not living with you _____ Relationship _____

Address _____ City/Zip _____ Home phone _____ Work phone _____

INSURANCE INFORMATION AND CONSENT

FATHER **Name of Insurance Company** _____ **Group/Policy No.** _____

Address _____ Union Local _____

MOTHER **Name of Insurance Company** _____ **Group/Policy No.** _____

Address _____ Union Local _____

Assignment of Benefits I hereby authorize payment of the group dental benefits otherwise payable to me but not to exceed the charges shown on the claim. I understand that I am financially responsible for any charges not covered by this authorization.

SIGNATURE _____ **DATE** _____

Consent I give the dentist permission to use such measures as deemed necessary in his/her professional judgment to render the best dental treatment for my child. I understand, that when appropriate, credit bureau reports may be obtained.

SIGNATURE _____ **DATE** _____

RELATIONSHIP TO PATIENT _____