San Diego Children's Dentistry

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Welcome to San Diego Children's Dentistry!

Please tell us a little about your family.

Your Family Information

Child's Full Name _____ Nickname _____ Sex _____
Age _____ Date of Birth ____/_____/_____ Interests _____
Primary E-mail address _____ Best Phone _____
Secondary E-mail address _____
Parent #1 Full Name _____ Cell Phone _____
Address_____ City _____ State ____ Zip _____
Date of Birth ____/_____/_____ Driver's License Number _____
Social Security Number _____ Occupation_____ Employer _____
Parent #2 Full Name _____ Cell Phone _____
Address_____ City _____ State ____ Zip _____
Date of Birth ____/_____/_____ Driver's License Number _____
Social Security Number _____ Occupation_____ Employer _____
Emergency Contact (other than parents)_____
Phone number_____ Relationship _____
Parents Marital Status_____ If parents are divorced, who has custody and how are financial obligations to be handling according to the decree? _____

_____

Stepmother's Full Name _____ Cell Phone _____
Stepfather's Full Name _____ Cell Phone _____

Your Family Medical Information

What is your impression of your child's overall health? _____
What is your impression of your child's oral health? _____
Does your child have tooth or mouth pain? _____ Pain Scale Today (0-10)_____
Height _____ Weight _____ lbs (_____ kg) Race/ethnicity_____
Primary Care Physician _____ Office Phone _____ Fax _____
Office Address_____ City _____ State ____ Zip _____
Date of Last Physical Exam: _____ Immunizations Up-to-date? Y / N
List all medications, supplements, and/or vitamins _____
_____
Does your child have any medical allergies (i.e.: latex, penicillin, metal, nut, food, etc)? Y / N
If yes, describe _____
Please mark any positive responses below:

- ○ Arthritis
- ○ Asthma
- ○ Asperger Syndrome
- ○ Autism Spectrum
- ○ Bleeding Disorders
- ○ Cancer
- ○ Celiac Disease
- ○ Cerebral Palsy
- ○ Cleft Palate
- ○ Cystic Fibrosis
- ○ Depression
- ○ Developmental Delays
- ○ Diabetes
- ○ Down Syndrome
- ○ Eating Disorder
- ○ GERD
- ○ Hay Fever
- ○ Hearing Problems
- ○ Heart Issues
- ○ Heart Murmur
- ○ Hepatitis
- ○ HIV/AIDS
- ○ Hydrocephaly/ Shunt
- ○ Hyperactivity, ADD, ADHD
- ○ Hypertension
- ○ Inherited Conditions
- ○ Intellectual Disability
- ○ Kidney Issues
- ○ Lactose Intolerance
- ○ Learning Disabilities
- ○ Liver Disease
- ○ Mitral Valve Prolapse
- ○ Multiple Sclerosis
- ○ Muscular Dystrophy
- ○ Premature Birth
- ○ Rheumatic Fever
- ○ Scoliosis
- ○ Seizure Disorder
- ○ Sickle Cell
- ○ Sleep apnea
- ○ Speech Problems
- ○ Thyroid Issues
- ○ Tourette's Syndrome
- ○ Tuberculosis
- ○ Tumor
- ○ Other _____
- ○ _____
  _____
  _____
  _____
  _____

Has your child ever had:
An adverse reaction to dental anesthetics, sedation medication, or antibiotics? **Y / N**
Surgery or general anesthesia? **Y / N** Hospitalization? **Y / N** Injury on face and/or mouth? **Y / N**
Bad dental experience? **Y / N** If yes on any of the above, please explain _____
_____
_____
Is there anything you want us to know before we treat your child? _____
_____
_____

Your Insurance Information

Primary Insurance Company _____
Address _____ City_____ State _____ Zip _____
Card Holder's Name _____ Relationship _____ Group # _____
Date of Birth ____/_____/_____ Social Security Number _____
Employer _____

Secondary Insurance Company _____
Address _____ City_____ State _____ Zip _____
Card Holder's Name _____ Relationship _____ Group # _____
Date of Birth ____/_____/_____ Social Security Number _____
Employer _____

Your Consent and Signature

As legal guardian, I authorize the office staff to perform the necessary dental treatment my child may need, including dental emergencies. I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence, and that it is my responsibility to inform this office of any changes in my child's medical status or insurance coverage. I acknowledge that I have been given the right to review the office's Notice of Privacy Practices (HIPAA). I authorize the release of information required to process insurance claims and direct all insurance benefits for services rendered by San Diego Children's Dentistry to this office. I understand that I am financially responsible for all charges, even if not paid by insurance. I authorize the use of my signature on all my insurance submissions, whether manual or electronic. Video taping in the office is forbidden unless formal consent is obtained from San Diego Children's Dentistry prior to treatment. I have been given an opportunity to ask any questions I may have regarding office polices.

Print Name/Signature _____/_____ Date _____
Print Name/Signature _____/_____ Date _____
Print Name/Signature _____/_____ Date _____
Print Name/Signature _____/_____ Date _____