



Welcome to Our Practice!



SOUTH BAY PEDIATRIC DENTISTRY

Child's Information

Child's Name (First and Last) _____ Nickname _____

Date of Birth _____ Age _____ Gender _____

Home Address _____
(Street) (City) (Zip)

School _____ Grade _____

Pediatrician _____

____ Mother ____ Stepmother ____ Guardian ____ Other (Please specify) _____

Name _____

Home Phone _____ Cell Phone _____ Work Phone _____

Date of Birth _____

Employer _____

Occupation _____ How Long Held? _____

Social Security # _____ Email Address _____

____ Father ____ Stepfather ____ Guardian ____ Other (Please specify) _____

Name _____

Home Phone _____ Cell Phone _____ Work Phone _____

Date of Birth _____

Employer _____

Occupation _____ How Long Held? _____

Social Security # _____ Email Address _____

Parent's Marital Status: Married Domestic Partnership Separated Divorced Single Widowed

*Responsible Party (If different from parents)

Name _____ Relationship _____

Home Phone _____ Work Phone _____

Date of Birth _____

Employer _____

Occupation _____ How Long Held? _____

Social Security # _____ Email Address _____

Whom may we thank for this referral?

Family or Friend _____ General Dentist _____ Pediatrician _____

Internet _____ Other (Please specify) _____

Primary Dental Insurance

Subscriber's Name _____ Relationship to Patient _____

Date of Birth _____ Social Security or ID Number _____

Employer _____

Insurance Company _____ Group # _____

Additional Insurance:

Subscriber's Name _____ Relationship to Patient _____

Date of Birth _____ Social Security or ID Number _____

Employer _____

Insurance Company _____ Group # _____

Date:

Dental History:

What would you like us to do for your child today? _____

Previous Dentist _____ Date of last dental care _____

May we contact your previous dentist to get copies of your child's previous dental records? Yes No

Has your child ever experienced a mouth or chin injury? Yes No

Please check all that apply: Speech Difficulty Thumb/Pacifier Habit Jaw Pain Grinds Teeth

*Other (Please specify) _____

Has your child ever experienced an adverse reaction during a dental/medical procedure? Yes No

* (If yes, please explain) _____

Other information about your child's previous treatment _____

Medical History

Please check all that apply:

<input type="checkbox"/> Y <input type="checkbox"/> N Aids/HIV+	<input type="checkbox"/> Y <input type="checkbox"/> N Convulsions/Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Digestive Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N ADD/ADHD	<input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impaired	<input type="checkbox"/> Y <input type="checkbox"/> N Skin Rash
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Cough, Persistent	<input type="checkbox"/> Y <input type="checkbox"/> N Brain Injury	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Blood Disease	<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Down's Syndrome	<input type="checkbox"/> Y <input type="checkbox"/> N Special Needs
<input type="checkbox"/> Y <input type="checkbox"/> N Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N Fainting	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems	<input type="checkbox"/> Y <input type="checkbox"/> N Autism
<input type="checkbox"/> Y <input type="checkbox"/> N Chicken Pox	<input type="checkbox"/> Y <input type="checkbox"/> N Respiratory Problems	<input type="checkbox"/> Y <input type="checkbox"/> N Liver Problems	

Additional explanations/comments _____

List medications your child is taking, if any: _____

Food Allergies: _____

Drug Allergies: _____

Material Allergies (ex. Latex): _____

Family Information

Name(s) of Sibling(s)

1: _____ Age _____ Grade _____

2: _____ Age _____ Grade _____

3: _____ Age _____ Grade _____

4: _____ Age _____ Grade _____

*Consent: I hereby authorize that all necessary dental services be rendered for _____

Patient's Name

Signature _____ Relationship _____ Date _____

Authorization: I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist. I authorize the dentist to release all information necessary to secure the payment of benefits.

Payment is due in full at time of treatment, unless prior arrangements have been approved. The difference (if any) between amounts paid by your insurance (where there is an assignment of benefits) and the amount billed is your responsibility.

Charges not paid within 90 days may be subjected to a "late payment" fee of 1.5% per month (18% annual percentage rate) until paid in full. Future services may be refused until the amount outstanding is no longer delinquent. Minimum "late payment" fee is 50 cents.

I am aware that there is a \$75 missed appointment fee for cancellation without 24 hours' notice.

I reviewed a copy of the Notice of Privacy Practices and the Dental Materials Fact Sheet and am aware that copies of both can be made available to me upon request.

Signature of Person Responsible for Account _____

Reviewed by: Nick Brajevich, DDS _____ Quinn Yost, DDS _____