Pediatric Dentistry of Valencia

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Welcome! We welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We believe in preventive maintenance, therefore we strive to teach good home oral care so you and your child will enjoy a beautiful smile for a lifetime. The more we know about your child the better we can assist both of you. To that end, this questionnaire has been designed. It only looks like it has a zillion questions and will actually take only a few minutes to fill out.

1 TELL US ABOUT YOUR CHILD

Today's date _____

Child's name _____ (Last / First / Mid. Int.) Nickname _____ ☐ Male ☐ Female

Child's Birthdate _____ Child's Age _____ School _____ Grade _____

Child's home address _____ (City / State / Zip Code)

Who is accompanying the child today? _____ (Last / First) Relation _____

Do you have legal custody of this child? ☐ Yes ☐ No Other family members seen by us? _____

I consent to the dental practice using this **phone number** _____ to (choose one or both) ☐ call ☐ text regarding appointments, treatment, insurance, and my account. I understand that I can withdraw my consent at any time. _____
Initial or Signature

I consent to the dental practice using this **email address** _____ regarding appointments, treatment, insurance, and my account. I understand that I can withdraw my consent at any time. _____
Initial or Signature

2 PARENTAL INFORMATION

Mother's Name _____ ☐ Stepmother ☐ Guardian Mother's Birthdate _____

Wk# _____ Cell# _____ Hm# _____ SS# _____ Driv lic# _____

Employer _____ Occupation _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced

Father's Name _____ ☐ Stepfather ☐ Guardian Father's Birthdate _____

Wk# _____ Cell# _____ Hm# _____ SS# _____ Driv lic# _____

Employer _____ Occupation _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced

3 PRIMARY DENTAL INSURANCE

Insurance co. name _____ Group# (Plan, local or policy#) _____ Insurance co. phone# _____

Insurance co. address _____

Insured's name _____ Relationship to patient _____

Insured's Birthdate _____ and SS# _____ Insured's employer _____ ID# _____

4 SECONDARY DENTAL INSURANCE

Insurance co. name _____ Group# (Plan, local or policy#) _____ Insurance co. phone# _____

Insurance co. address _____

Insured's name _____ Relationship to patient _____

Insured's Birthdate _____ and SS# _____ Insured's employer _____ ID# _____

(continue on other side please!)

5 DENTAL HISTORY

Whom may we thank for referring you? _____ Is this your child's first dental visit? ☐ Yes ☐ No Previous Dentist _____

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

Has your child experienced any problems with previous dental work? ☐ Yes ☐ No If Yes (PLEASE EXPLAIN) _____

Is your child nervous or frightened about dental visits? ☐ Yes ☐ Somewhat ☐ No ☐ This is our first visit

Has there been any injury or trauma to teeth, jaw, or chin? ☐ Yes ☐ No If Yes (PLEASE EXPLAIN) _____

Is your child taking fluoride supplements or drinking fluoridated water? ☐ Yes ☐ No

Has your child ever been seen by an orthodontist? ☐ Yes (WHO?) _____ ☐ No

Does your child brush his/her teeth twice daily? ☐ Yes ☐ No Do they need parental help? ☐ Yes ☐ No Floss daily? ☐ Yes ☐ No Needs help? ☐ Yes ☐ No

Child's pediatrician _____ Phone# _____ Date of last visit _____

Is your child currently under care of a physician? ☐ Yes (WHO?) _____ ☐ No

Has your child had any of the following:

- ☐ Thumb / Finger / Lip Sucking Habits
- ☐ Pacifier Sucking Habits
- ☐ Sleep Apnea / Snoring
- ☐ Mouth Breathing
- ☐ Nursing / Bottle Habits
- ☐ Clenching / Grinding
- ☐ Speech Problems
- ☐ TMJ / TMD Pain

Is your child allergic to any substance, food, latex, or medicine? ☐ Yes ☐ No

Explain _____

Please list all medication your child is currently taking: _____

6 MEDICAL HISTORY

please check all that apply

- ☐ **ADD / ADHD**
- ☐ **Allergies**
- ☐ **Anemia**
- ☐ **Asthma**
- ☐ **Autism Spectrum**
- ☐ **Behavioral Disabilities**
- ☐ **Bleeding Disorder**
- ☐ **Blood Pressure Problems**
- ☐ **Blood Transfusion**
- ☐ **Bone Disorders**
- ☐ **Brain Injury**
- ☐ **Breathing Problems**
- ☐ **Cancer / Tumors**
- ☐ **Catheters / Ports**
- ☐ **Congenital Birth Defect**
- ☐ **Congenital Heart Defect**
- ☐ **Convulsion / Epilepsy**
- ☐ **Diabetes**
- ☐ **Endocrine Disorders**
- ☐ **Frequent Infections**
- ☐ **Frequent Nose Bleeds**
- ☐ **Gastrointestinal Problems**
- ☐ **Growth Problems**
- ☐ **Handicaps / Disabilities**
- ☐ **Hearing Impairment**
- ☐ **Heart Murmur**
- ☐ **Heart Problems**
- ☐ **Hemophilia**
- ☐ **Hepatitis**
- ☐ **HIV+ / AIDS**
- ☐ **Immune Deficiency**
- ☐ **Kidney Problems**
- ☐ **Learning Disabilities**
- ☐ **Liver Problems**
- ☐ **Mental Disabilities**
- ☐ **Orthopedic Rods / Pins / Plates**
- ☐ **Physical Disabilities**
- ☐ **Rheumatic Fever**
- ☐ **Sickle Cell Anemia**
- ☐ **Significant Injuries**
- ☐ **Tuberculosis (TB)**
- ☐ **Vision Problems**
- ☐ **Any Stays in a hospital**
- ☐ **Any Operations**
- ☐ **Other** (PLEASE SPECIFY BELOW)

If any of the above is checked, please detail here: _____

OUR OFFICE IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MANDATED BY OSHA, THE CDC AND THE ADA.

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 of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I authorize Pediatric Dentistry of Valencia to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payers and/or other health practitioners. I consent to their use and disclosure of my children(s) Protected Health Information to carry out treatment, payment activities, and healthcare operations. I hereby acknowledge that copies of this practice's Notice of Privacy Practices (HIPAA) and Dental Materials Fact Sheet have been made available to me. I have been given the opportunity to ask any questions I may have regarding these two forms.

_____
Print Name Relation to Patient

✘ _____
Signature Date

Office Use Only • Office Use Only • Office Use Only • Office Use Only

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

Initials _____ Date _____

Doctor's Comments _____

Medical History Update

1. Date _____ Signature _____

Comments _____

2. Date _____ Signature _____

Comments _____

3. Date _____ Signature _____

Comments _____

Thank You!