We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions, we will be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date: _____

Name of Minor/Child: _____
Last Name First Name Middle Name

Sex: ☐ M ☐ F Age: _____ Birth date: _____ Nickname: _____

Hobbies: _____

Home Address: _____
Street City State Zip

Mailing Address: _____
Street City State Zip

Person Financially Responsible: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Whom may we thank for referring you? _____

PARENT/GUARDIAN INFORMATION

Father's/Guardian's Name: _____

Address (if different): _____

Home Phone: _____ Work Phone: _____

Employer: _____

Social Security #: _____ Birth date: _____

Mother's/Guardian's Name: _____

Address (if different): _____

Home Phone: _____ Work Phone: _____

Employer: _____

Social Security #: _____ Birth date: _____

Do you have dental insurance coverage for your minor/child? ☐ Yes ☐ No

Plan Name: _____

Group Number: _____

Policy #: _____

Parent's/guardian's are expected to pay deductible and applicable co-payment percentage when services are rendered. Insurance is a contract between you and your insurance company. We are not a party to this contract. We file claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company. You will always be responsible for the timely payment of your account. **We do not accept payment plans. Payment is due when services are rendered.**

DENTAL HISTORY

Date of last visit to a dentist: _____ For what service? _____

Reason for today's visit: _____

Has child complained about dental problems? ☐ Yes ☐ No

Does child brush teeth daily? ☐ Yes ☐ No

Does child use floss every day? ☐ Yes ☐No

Is fluoride taken in any form? ☐ Yes ☐ No

Any injuries to mouth, teeth, head? ☐ Yes ☐ No

Any problems with the jaws (pain," popping", "locking")? ☐ Yes ☐No

Any mouth habits – thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? (please specify) ☐ Yes ☐No

Any unhappy dental experiences? ☐ Yes ☐ No _____

Please describe your child's personality/temperament: _____

Are there any behavioral issues you would like to discuss with the dentist? ☐ Yes ☐ No _____

Name of Minor/Child: _____ Birth date: _____

MEDICAL HISTORY

Child's Physician: _____ City: _____ Phone: _____

Date of last Physical Examination: _____ Results: _____

Is Minor/Child under care of physician now? ☐ Yes ☐ No Explain: _____

Receiving any medications or drugs? ☐ Yes ☐ No Medications: _____

Allergies to medicines or drugs? ☐ Yes ☐ No Allergies: _____

Ever been hospitalized? ☐ Yes ☐ No Comments: _____

Ever had surgery? ☐ Yes ☐ No _____

Is there excessive bleeding when cut? ☐ Yes ☐ No _____

HAS MINOR/CHILD HAD ANY HISTORY OR DIFFICULTY WITH ANY OF THE FOLLOWING?

	YES	NO		YES	NO		YES	NO
A.I.D.S./H.I.V.	☐	☐	Epilepsy	☐	☐	Pneumonia	☐	☐
Anemia	☐	☐	Eye Problems	☐	☐	Polio	☐	☐
Allergy	☐	☐	Excessive Bleeding Problem	☐	☐	Pregnancy	☐	☐
Arthritis	☐	☐	Fainting	☐	☐	Psychiatric Disorder	☐	☐
Asthma	☐	☐	Hearing Loss	☐	☐	Rheumatic Fever	☐	☐
Autism/P.D.D.	☐	☐	Heart Disease	☐	☐	Scarlet Fever	☐	☐
Blood Transfusion	☐	☐	Heart Murmur	☐	☐	Scoliosis	☐	☐
Brain Injury	☐	☐	Hemophilia	☐	☐	Sickle Cell Anemia	☐	☐
Bronchitis	☐	☐	Hepatitis – Type _____	☐	☐	Sinus Problems	☐	☐
Cancer	☐	☐	Jaundice	☐	☐	Snoring at Night	☐	☐
Cerebral Palsy	☐	☐	Leukemia	☐	☐	Sore Throats – Frequent	☐	☐
Chicken Pox	☐	☐	Measles	☐	☐	Spina Bifida	☐	☐
Cleft Lip/Palate	☐	☐	Mental Retardation	☐	☐	Syndrome _____	☐	☐
Convulsions/Seizures	☐	☐	Mumps	☐	☐	Tetanus	☐	☐
Diabetes	☐	☐	Mouth Breathing	☐	☐	Tuberculosis	☐	☐
Diphtheria	☐	☐	Nutritional Deficiency	☐	☐	Venereal Disease	☐	☐
Drug/Alcohol Abuse	☐	☐	Orthopedic Problems	☐	☐	Whooping Cough	☐	☐

Other: _____

EMERGENCY CONTACT - In the event of an emergency, whom should we contact?

Name: _____ Relationship: _____ Phone: _____

AUTHORIZATIONS

The information I have given is correct to the best of my knowledge. I understand that it will be in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform necessary dental services for my minor/child, including, but not limited to, X-rays and administration of anesthetics which are deemed advisable by the doctor. Although rare, some risks have been reported to be associated with dental or oral surgery procedures. Some of the possible risks include numbness, infection, swelling, bleeding, discoloration, nausea, vomiting, allergic reactions, brain damage, quadriplegia, the loss of function of any organ or limb, or disfiguring scars associated with such procedures. I understand and accept that complications may require hospitalization and may result in death. I have read and understand this consent, and all questions have been answered. I understand that this consent will remain in effect until such time that I choose to terminate it in writing.

Signature of parent/guardian: _____ Date: _____

I certify that my minor/child is covered by insurance with _____ and assign directly to Josefina V.
Name of Insurance Company
Martinez, DDS all insurance benefits, if any, payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance admissions, whether manual or electronic.

Signature of parent/guardian: _____ Date: _____

MISSED APPOINTMENTS

All attempts are made to confirm appointments prior to the appointment date. If we are unable to contact you directly, it will become your responsibility to call us at least 24 hours in advance to confirm your minor/child's appointment. Failure to do so may result in your minor/child losing his/her appointment in order to treat other patient needs. In addition, patients will be dismissed from the practice after two failed appointments. Cancellations must be made at least 24 hours in advance. I have read and understand this agreement.

Signature of parent/guardian: _____ Date: _____