WELCOME

1 About Your Child

Today's Date: ____/____/____ File #: ____________

Child's Name: ______________________________
LAST FIRST M.I.

Child's Nickname: ____________________ ❑ Boy ❑ Girl

Child's Birthdate: ____/____/____ Age: ________

School: ____________________ Grade: ________

Child's Home Phone #: (______) ______________

Child's SS#: ______________________________

Child's Address: ______________________________
HOME ADDRESS

____
CITY STATE ZIP

Referred By: ______________________________
(If doctor, please give address & phone number.)

____

2 Insurance Information

Primary Dental Insurance

Co. Name: ______________________________

Address: ______________________________

____
CITY STATE ZIP

Phone #: ______________________________

Insured's ID#: ______________________________

Group # (Plan, Local, or Policy #): ______________________________

Insured's Name: ______________________________

Relation: ______________ Date of Birth: ___/___/___

Insured's Employer: ______________________________

Does either policy cover Orthodontics? ❑ Yes ❑ No

Secondary Dental Insurance

Co. Name: ______________________________

Address: ______________________________

____
CITY STATE ZIP

Phone #: ______________________________

Insured's ID#: ______________________________

Group # (Plan, Local, or Policy #): ______________________________

Insured's Name: ______________________________

Relation: ______________ Date of Birth: ___/___/___

Insured's Employer: ______________________________

3 Child's Family Information

Who is accompanying this child today?

______________________________ ______________________________
FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? ❑ Yes ❑ No

How many Brothers/Sisters? ________ Age(s): ____ ____ ____

______________________________ ______________________________
MOTHER'S NAME ❑ STEP MOTHER ❑ GUARDIAN EMAIL ADDRESS

____
(❑ CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

(______)__________ (______)__________ ______
HOME PHONE # WORK PHONE # EXT.

__________ ___/___/___ __________
MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LIC. #

Employer: ______________________ How Long? ________

____
EMPLOYER'S ADDRESS CITY STATE ZIP

______________________________ ______________________________
FATHER'S NAME ❑ STEP FATHER ❑ GUARDIAN EMAIL ADDRESS

____
(❑ CHECK IF SAME AS CHILD'S) HOME ADDRESS CITY STATE ZIP

(______)__________ (______)__________ ______
HOME PHONE # WORK PHONE # EXT.

__________ ___/___/___ __________
FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LIC. #

Employer: ______________________ How Long? ________

____
EMPLOYER'S ADDRESS CITY STATE ZIP

4 Account Information

Person ultimately responsible for account

Name: ______________________ ______________
RELATION TO CHILD

Billing Address: ______________________________

____
CITY STATE ZIP

__________ ___/___/___ __________
SOCIAL SECURITY # DATE OF BIRTH DRIVERS LIC. #

(______)__________ ______ (______)__________
WORK PHONE # EXT. CELL PHONE #

Payment method: ❑ Cash ❑ Check

______________________________ ____/____

❑ Credit Card - Enter card # above (if accepted)

________ I hereby authorize assignment of my insurance rights and
Initials
benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Please Continue On Back

5 Child's Dental Information

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation

Is Child in pain? ☐ No ☐ Yes How Long? ____________

Please indicate ☑ any of the following problems:

☐ Discomfort, clicking or popping in jaw. ☐ Lost/Broken Filling(s) ☐ Stained teeth
☐ Red, swollen or bleeding gums. ☐ Teeth grinding ☐ Locking Jaw
☐ Sensitive tooth, teeth or gums. ☐ Ringing in Ears ☐ Bad breath
☐ Blisters/Sores in or around the mouth. ☐ Broken/Chipped tooth ☐ Loose tooth
☐ Other(s): ____________

Does child require pre-medication? ☐ Yes ☐ No ☐ Don't know

Previous Dentist: ____________ (____) ____________

Last Dental exam: ____ /____ /____ Last Dental X-rays: ____ /____ /____

Times a day child brushes? ______ Times a week child flosses? ______

Is the child's water fluoridated? ☐ Yes ☐ No

How would you rate the child's smile? **Best** 1 2 3 4 5 6 7 8 9 10 **Worst**

6 Child's Medical History

Is Child taking any of the following medications? ☐ Pain killers (INCLUDING ASPIRIN) ☐ Ritalin ☐ Stimulants
☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Muscle relaxers ☐ Others: ____________

Child's Physician: ____________ (____) ____________
DOCTOR'S NAME OR CLINIC NAME PHONE#

____________ Last Medical Exam: ____ /____ /____
ADDRESS CITY STATE ZIP

Does Child have or ever had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur
Y N Rheumatic fever
Y N Artificial Heart Valves
Y N Congenital Heart defect
Y N Scarlet Fever
Y N Surgeries/Operations
Y N Cancer/Tumors
Y N Chemotherapy
Y N Jaw Problems TMJ/TMD
Y N Hearing Problems
Y N Tonsillitis
Y N Respiratory Problems
Y N Asthma/Difficulty Breathing
Y N Blood Transfusion(s)
Y N Leukemia/Anemia
Y N Diabetes/Hypoglycemia
Y N Hemophilia
Y N Abnormal Bleeding
Y N Cleft Lip/Palate
Y N Birth Defects
Y N High/Low Blood Pressure
Y N Hepatitis
Y N Artificial Bones/Joints/Implants
Y N Liver/Kidney/Organ Problems
Y N HIV+/AIDS/ARC
Y N Tuberculosis TB
Y N Psychiatric Problems
Y N Hyper Active/ADD
Y N Fainting/Seizures/Epilepsy
Y N Cerebral Palsy

Please list any other medical condition(s) child has or ever had: ____________

Is Child allergic to: ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Dental Anesthetics (Novocaine)
☐ Aspirin ☐ Food allergies ☐ Other(s): ____________

Please rate the child's general health from 1-10: ______ Does child wear contact lenses? ☐ Yes ☐ No

Has this child ever taken the drug Ritalin? ☐ No ☐ Yes/How long? ______ Child's Blood type: ______

Does this child do any of the following? ☐ Thumb/Finger Sucking ☐ Tongue Thrusting/Sucking
☐ Heavy Snoring ☐ Mouth Breathing ☐ Lip Sucking/Biting

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I acknowledge that I have received a copy of the Summary of Privacy Notice.

______ Initials

Signature ____________ Date ____ / ____ / ____
☐ Parent or Guardian ☐ Other:

UPDATE (OFFICE USE)

Initials ______ Date __ / __ /
Comments

Initials ______ Date __ / __ /
Comments

Initials ______ Date __ / __ /
Comments

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WELCOME

one — ABOUT YOU

Today's Date: ____/____/____ File #: ____

Patient Name: ____ (LAST / FIRST / MI)

What You Prefer To Be Called: ____ ❑ Male ❑ Female

Birthdate: ____/____/____ Age: ____ SS#: ____

Mailing Address: ____

CITY / STATE / ZIP

Home Phone #: ( ) ____

Work Phone #: ( ) ____ Ext: ____

Cell Phone #: ( ) ____

E-mail Address: ____

Referred By: ____

Employer: ____ How Long? ____

Employer's Address: ____

CITY / STATE / ZIP

Occupation: ____

Status: ❑ Minor ❑ Single ❑ Married ❑ Divorced ❑ Separated ❑ Widowed

Spouse's Name: ____

Do you have children? ❑ Yes ❑ No How many? ____

two — INSURANCE INFO

Primary Dental Insurance

Co. Name: ____

Address: ____

CITY / STATE / ZIP

Phone #: ( ) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

Secondary Dental Insurance

Co. Name: ____

Address: ____

CITY / STATE / ZIP

Phone #: ( ) ____

Insured's ID#: ____

Group # (Plan, Local, or Policy #): ____

Insured's Name: ____

Relation: ____ Date of Birth: ____/____/____

Insured's Employer: ____

three — ACCOUNT INFO

Person ultimately responsible for account

Name: ____

Relation: ____

Billing Address: ____

CITY / STATE / ZIP

SS #: ____

Drivers License #: ____

Work Phone #: ( ) ____

Payment method: ❑ Cash ❑ Check

____ ____/____

❑ Credit Card - Enter card # above (if accepted)

____ Initials I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

four — IN EVENT OF EMERGENCY

Whom should we contact? ____

Relation: ____

Home Phone #: ( ) ____

Work Phone #: ( ) ____

Cell Phone #: ( ) ____

Who is your Medical Doctor? ____

Medical Doctor's Phone #: ( ) ____

five 5

DENTAL INFORMATION

Reason for today's visit: ❑ Exam ❑ Emergency ❑ Consultation

Are you in pain? ❑ No ❑ Yes How Long? ____________

Please indicate ☑ any of the following problems:

❑ Discomfort, clicking or popping in jaw. ❑ Lost/Broken Filling(s) ❑ Stained teeth
❑ Red, swollen or bleeding gums. ❑ Teeth grinding ❑ Locking Jaw
❑ Sensitive tooth, teeth or gums. ❑ Ringing in Ears ❑ Bad breath
❑ Blisters/Sores in or around the mouth. ❑ Broken/Chipped tooth

❑ Other: ____________

Do you require pre-medication? ❑ Yes ❑ No ❑ Don't know

Previous Dentist: ____________ Name (____) ____________ Phone#

Last Dental exam: ____ / ____ / ____ Last Dental X-rays: ____ / ____ / ____

Times a day you brush? ________ Times a week you floss? ________

What type of tooth brush bristles do you use? ❑ Soft ❑ Medium ❑ Hard

How would you rate your smile? (Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

six 6

MEDICAL HISTORY

What medications are you taking? ❑ **Nerve pills** ❑ **Pain killers** (including aspirin) ❑ **Muscle relaxers**
❑ **Stimulants** ❑ **Blood Thinners** ❑ **Tranquilizers** ❑ **Insulin** ❑ **Meds for Osteoporosis**
❑ **Other(s), please list:** ____________

Have you ever taken: Bisphosphonates (ex. Aredia/Fosamax) ❑ Yes ❑ No Phen-fen/Redux ❑ Yes ❑ No

Do you have or have you had any of the following diseases, medical conditions or procedures?

Y N Heart Attack / Stroke	**Y N** Thyroid Problems	**Y N** Cancer/Tumors	**Y N** Cosmetic Surgery
Y N Heart Surg./Pacemaker	**Y N** Kidney Problems	**Y N** Shingles	**Y N** Xray or Cobalt Treatment
Y N Heart Murmur	**Y N** Liver Problems	**Y N** Hepatitis	**Y N** Chemotherapy
Y N Rheumatic Fever	**Y N** Respiratory Problems	**Y N** HIV+/AIDS/ARC	**Y N** Asthma
Y N Mitral Valve Prolapse	**Y N** Sinus Problems	**Y N** Arthritis/ Rheumatism	**Y N** Difficulty Breathing
Y N Artificial Valves	**Y N** Stomach Problems/Ulcers	**Y N** Artificial Bones/Joints	**Y N** Diabetes/Hypoglycemia
Y N Heart Disease	**Y N** Psychiatric Problems	**Y N** Emphysema	**Y N** Leukemia
Y N Congenital Heart Defect	**Y N** Venereal Disease	**Y N** Fainting/Seizures/Epilepsy	**Y N** Anemia
Y N Chest Pains	**Y N** Alcohol/Drug Abuse	**Y N** Severe/Frequent Headaches	**Y N** High/Low Blood Pressure
Y N Scarlet Fever	**Y N** Tuberculosis TB	**Y N** Frequent Neck Pain	**Y N** Bleeding Problems
Y N Nervousness	**Y N** Jaw Problems TMJ/TMD	**Y N** Back Problems	**Y N** Glaucoma

Please list any other surgeries or medical conditions you have or ever had: ____________

Are you allergic to any of the following? ❑ Latex ❑ Penicillin / Amoxicillin ❑ Tetracycline ❑ Aspirin

❑ Dental Anesthetics ❑ Foods: ____________ ❑ Others: ____________

Do you use tobacco? ❑ No ❑ Yes/How used? ________ How much? ______ How long? ______

Please rate your general health from 1-10: ________ Do you wear contact lenses? ❑ Yes ❑ No

For women: Are you taking Birth Control pills? ❑ Yes ❑ No How many children have you had? ______

Are you Pregnant? ❑ No ❑ Yes/How long? ______ Are you nursing? ❑ Yes ❑ No

PLEASE RECYCLE SO THAT WE MAY PRESERVE THE HEALTH OF OUR PLANET

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

I acknowledge that I have received a copy of the Summary of Privacy Notice.

______ Initials

Signature ____________ ❑ Adult Patient ❑ Parent or Guardian ❑ Spouse Date ____ / ____ / ____

UPDATE (OFFICE USE)

Initials	Date
______	/ /
Comments	
______	/ /
Comments	
______	/ /
Comments	

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BIENVENIDO

1 uno — DATOS PERSONALES

Fecha: ____/____/____ Número de archivo: ____________

Nombre: ____________________________
APELLIDO NOMBRE

Apodo: ____________ ❑ Masculino ❑ Femenino

Fecha de Nacimiento: ____/____/____ Edad: ______

de Seguro Social (#SS): ____________

Dirección: ____________________________

CIUDAD ESTADO CODIGO POSTAL

Teléfono Casa: (______) ____________

Teléfono Trabajo: (______) ____________ Ext: ______

Teléfono Celular: (______) ____________

Dirección electrónica: ____________

¿Quién le recomendó esta oficina? ____________

Empleador: ____________ ¿Desde Cuándo? ______

Dirección del trabajo: ____________

CIUDAD ESTADO CODIGO POSTAL

Cargo: ____________

Estado Civil: ❑ Menor ❑ Soltero(a) ❑ Casado(a) ❑ Divorciado(a) ❑ Separado(a) ❑ Viudo(a)

Nombre de su cónyuge: ____________

¿Tiene hijos? ❑ Sí ❑ No ¿Cuántos? ______

2 dos — INFORMACION DE SU SEGURO

Seguro Dental Primario

Nombre de la Compañía: ____________

Dirección: ____________

CIUDAD ESTADO CODIGO POSTAL

Teléfono: (______) ____________

IDN del asegurado(a): ____________

del grupo (Plan, Local o Póliza): ____________

Nombre del asegurado(a): ____________

Parentesco: ____________

Fecha de Nacimiento: ____/____/____

Empleador del asegurado(a): ____________

Seguro Dental Secundario

Nombre de la Compañía: ____________

Dirección: ____________

CIUDAD ESTADO CODIGO POSTAL

Teléfono: (______) ____________

IDN del asegurado(a): ____________

del grupo (Plan, Local o Póliza): ____________

Nombre del asegurado(a): ____________

Parentesco: ____________

Fecha de Nacimiento: ____/____/____

Empleador del asegurado(a): ____________

3 tres — INFORMACION DE LA CUENTA

Persona Responsable por la Cuenta

Nombre: ____________

Parentesco: ____________

Dirección: ____________

CIUDAD ESTADO CODIGO POSTAL

de Seguro Social: ____________

Licencia de Conducir: ____________

Teléfono del Trabajo: (______) ____________

Forma de Pago: ❑ Efectivo ❑ Cheque ❑ Tarjeta de Crédito

____________ ____/____
Número de Tarjeta (En caso de ser aceptado) Fecha de Vencimiento

______ (Iniciales) Autorizo a que se asignen los derechos y beneficios de mi seguro directamente al proveedor de los servicios prestados. Entiendo perfectamente que soy responsable por la cantidad no cubierta por mi seguro. (si este servicio es ofrecido en esta oficina)

4 cuatro — EN CASO DE EMERGENCIA

Llamar a: ____________

Parentesco: ____________

Teléfono Casa: (______) ____________

Teléfono Trabajo: (______) ____________

Teléfono Celular: (______) ____________

Nombre de su Doctor: ____________

Teléfono de su Doctor: (______) ____________

CONTINUA AL DORSO

5 cinco

INFORMACION ODONTOLOGICA

¿Cuál es la razón de su visita? ❑ Examen ❑ Emergencia ❑ Consulta
¿Tiene dolor? ❑ No ❑ Sí ¿Desde cuando? ____

Por favor indique ☑ si presenta alguno de los siguientes problemas:

❑ Molestia, chasquido o dislocación de la quijada. ❑ Calza partida o perdida. ❑ Dientes manchados.
❑ Encías enrojecidas, inflamadas o sangrantes. ❑ Crujido de los dientes. ❑ Mandíbula trabada.
❑ Sensibilidad dental o encias. ❑ Silvido en los oídos. ❑ Mal aliento.
❑ Ampollas o llagas dentro o alrededor de la boca. ❑ Diente partido o astillado.

❑ Otros problemas: ____

¿Requiere medicación previa? ❑ Sí ❑ No ❑ No sé.

Odontologo anterior: ____ (NOMBRE) Teléfono: (____) ____

Ultimo examen Dental: ___/___/___ Ultima radiografía Odontológica. ___/___/___

¿Cuántas veces se cepilla los dientes? ____ (DIARIO) ¿Cuántas veces utiliza hilo dental? ____ (SEMANAL)

¿Qué tipo de cepillo dental usa? ❑ Suave ❑ Mediano ❑ Duro

¿Cómo calificaría su sonrisa 1 -10? (deficiente) 1 2 3 4 5 6 7 8 9 10 (excelente)

6 seis

HISTORIA MEDICA

¿Esta Ud. tomando alguno de los siguientes medicamentos? ❑ **Para el Sistema Nervioso** ❑ **Calmantes para el Dolor (incluyendo aspirina)** ❑ **Relajantes musculares** ❑ **Estimulantes** ❑ **Adelgazantes de la sangre** ❑ **Tranquilizantes** ❑ **Insulina** ❑ **Para Osteoporosis**

❑ **Otros:** ____

Alguna vez ha tomado: Sodio Alendronate (ej. Fosamax) ❑ Sí ❑ No Phen–fen/Redux ❑ Sí ❑ No

¿Presenta Ud. o ha presentado alguna de las siguientes enfermedades, condiciones o procedimientos médicos?

S N Ataque Cardíaco / Derrame
S N Cirugía del Corazón / Marcapasos
S N Soplo Cardíaco
S N Fiebre Reumática
S N Prolapso de la Válvula Mitral
S N Válvulas Artificiales
S N Enfermedad Cardiaca
S N Defecto Cardíaco Congénito
S N Dolores en el Pecho
S N Fiebre Escarlata
S N Nerviosismo
S N Problemas de la Tiroides
S N Problemas de los Riñones
S N Problemas del Hígado
S N Problemas Respiratorios
S N Problemas de Sinusitis
S N Problemas Estomacales / Ulceras
S N Problemas Psiquiátricos
S N Enfermedad Venérea
S N Abuso de Alcohol / Drogas
S N Tuberculosis TB
S N Disfunción / Síndrome de la articulación Temporomandibular
S N Cáncer / Tumores
S N Herpes (Shingles)
S N Hepatitis
S N VIH+ / SIDA / ARC
S N Artritis / Reumatismo
S N Huesos / Coyunturas Artificiales
S N Enfisema
S N Desmayos / Convulsiones / Epilepsia
S N Dolores de Cabeza frecuentes / Severos
S N Dolor Frecuente en el Cuello
S N Problemas de la Espalda
S N Cirugía Cosmética
S N Tratamiento de Rayos X o Cobalto
S N Quimioterapia
S N Asma
S N Dificultad Respiratoria
S N Diabetes / Hipoglicemia
S N Leucemia
S N Anemia
S N Presión Arterial Alta / Baja
S N Trastornos Hemorrágicos
S N Glaucoma

Por favor mencione cualquier otra cirugía o condición médica que Ud. tenga o haya tenido: ____

¿Es Ud. alérgico a alguno de los siguientes medicamentos? ❑ Latex ❑ Penicilina/Amoxilina ❑ Tetraciclina ❑ Aspirina ❑ Anestésicos dentales ❑ Otros: ____

¿Consume Ud. tabaco? ❑ No ❑ Sí/¿Cómo lo consume? ____ ¿Cuanto? ____ ¿Desde Cuándo? ____

Por favor evalúe su salud general, en escala de 1-10: ____ ¿Utiliza Ud. lentes de contacto? ❑ Sí ❑ No

Para Mujeres: ¿Esta Ud. tomando Anticonceptivos? ❑ Sí ❑ No ¿Cuántos hijos ha tenido? ____

¿Esta Ud. embarazada? ❑ No ❑ Sí/¿Desde Cuándo? ____ ¿Esta Ud. amamantando? ❑ Sí ❑ No

- Le invitamos a aclarar cualquier inquietud relacionada con nuestro servicio. El mejor servicio se basa en un entendimiento mutuo y sincero entre el paciente y el proveedor.
- Nuestra oficina requiere que los servicios prestados sean pagados en su totalidad al término de la visita, a menos que se haya hecho otro acuerdo con la gerencia administrativa. Si su cuenta no ha sido pagada dentro de 90 dias a partir de la fecha de su servicio, y ningún arreglo financiero se ha establecido, Ud. será responsable por gastos legales, gastos por agencia de cobro, cargos de interés y demás gastos que se ocasionen.
- Autorizo al personal a realizar cualquier servicio necesario durante el diagnóstico y tratamiento, con el fin de procesar el seguro. Además autorizo al proveedor a suplir cualquier información requerida.
- Tengo pleno conocimiento de la información anterior, y garantizo, a mi entender, que es correcta y completa. Entiendo que es mi responsabilidad informar a ésta oficina sobre cualquier cambio en la información proporcionada.

Firma ____ Fecha ___/___/___
❑ Paciente Adulto ❑ Pariente o Guardian ❑ Cónyuge

UPDATE (OFFICE USE)

Initials ____ Date ___/___/___
Comments ____
Initials ____ Date ___/___/___
Comments ____
Initials ____ Date ___/___/___
Comments ____

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