Welcome Forms

Ladera Ranch
PEDIATRIC DENTISTRY
... growing healthy smiles

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach proper oral health care that will enable your child to have a beautiful smile that lasts a lifetime. The information requested below is very important and becomes part of our permanent records. Please make sure your answers are as complete and accurate as possible.

Tell Us About Your Child:

Today's Date: _____

Name: _____

Nickname: _____

Birth Date: _____

Age: _____ Gender: ◉ Male ○ Female

Home Address: _____ City: _____ State: _____ Zip: _____

School: _____ Grade: _____

Name/Age of Siblings: _____

Siblings Seen by Us That Child Lives With?

_____

Adopted? ○ Yes ○ No

Who can we thank for referring you?

_____

Health History

Child's Physician: _____ Phone: ( ) _____

Date of last visit: _____ Address: _____

Is your child currently under the care of a physician? (•) Yes ( ) No

Please explain: _____

Please describe your child's current physical health: (•) Good ( ) Fair ( ) Poor

Are Immunizations Current? (•) Yes ( ) No

Please list all medications and dosage that your child is currently taking:

_____

Please list all drugs and/or things that cause your child allergic reactions:

_____

Has your child had/experienced any of the following?:

Y( ) N(•) Abnormal Bleeding
Y( ) N(•) AIDS/HIV+
Y( ) N(•) Allergies
Y( ) N(•) Anemia
Y( ) N(•) Any Hospital Stays
Y( ) N(•) Any Operations
Y( ) N(•) Asthma
Y( ) N(•) Behavior/Learning/Disabilities
Y( ) N(•) Blood Dyscrasis
Y( ) N(•) Blood Transfusion
Date: _____
Y( ) N(•) Breathing/Lung Problems
Y( ) N(•) Cancer/Tumors
Y( ) N(•) Chicken Pox
Y( ) N(•) Congenital Birth Defect
Y( ) N(•) Congenital Birth Disease
Y( ) N(•) Diabetes
Y( ) N(•) Endocrine System Disorders
Y( ) N(•) Epilepsy
Y( ) N(•) Frequent Infections
Y( ) N(•) Handicaps:
_____
Y( ) N(•) Hearing Impaired
Y( ) N(•) Heart Murmur
Y( ) N(•) Hemophilia
Y( ) N(•) Hepatitis
Y( ) N(•) High Blood Pressure
Y( ) N(•) Hives
Y( ) N(•) Kidney Problems
Y( ) N(•) Liver/CI System Problems
Y( ) N(•) Low Blood Pressure
Y( ) N(•) Lupus
Y( ) N(•) Measles
Y( ) N(•) Mentally Physically Disabled
Y( ) N(•) Mitral Valve Prolapse
Y( ) N(•) Mononucleosis
Y( ) N(•) Rheumatic Fever
Y( ) N(•) Recurrent Headaches
Frequency: _____
Y( ) N(•) Scarlet Fever
Y( ) N(•) Seizures
Y( ) N(•) Sickle Cell Anemia
Y( ) N(•) Sight Disorders
Y( ) N(•) Significant Injuries
List
_____
_____
Y( ) N(•) Skin Rash
Y( ) N(•) Tonsillitis
Y( ) N(•) Tuberculosis (TB)

1. Has your child ever been hospitalized? Yes( ) No(•) If so, when? _____
   For what reason? _____
2. Has your child had any operations? Yes( ) No(•) If so, when? _____
   For what reason? _____
3. Does your child bruise easily? Yes(•) No( )
4. Has there ever been any history of spontaneous bleeding (e.g. , nose bleeds) or prolonged bleeding following tooth removal surgery, cuts, etc.? _____

Dental History

1. Please check reason(s) for seeking dental care:

- ☐ First Examination
- ☐ Routine check-up
- ☐ Toothache or swelling
- ☐ Other _____
- ☐ Appearance of teeth or face
- ☐ Crowding Teeth
- ☐ Accident

2. If your child has been to a dentist previously:

   a. When was the last visit? _____

   b. Have x-rays been taken and when? ◉ Yes ○ No Date _____

   c. How would you describe your child's temperament? _____

3. How do you think your child would react to dental treatment? _____

4. Has your child had fluoride in any of the following forms?

   a. Fluoride tables or in vitamins (Fluoride amt. ○ .25 ○ .5 ○ 1.0 mg) ◉ Yes ○ No

   b. Drinking water (community fluoridation) ○ Yes ◉ No

   c. Topical application to teeth? ◉ Yes ○ No When is last _____

   d. Toothpaste brand _____

5. Does your child brush his/her own teeth? ◉ Yes ○ No

   How frequently and when? ☐ AM ☐ PM ☐ After Snacks ☐ Before Bed ☐ After Breakfast

6. Do you brush your child's teeth? ◉ Yes ○ No

   How frequently and when? ☐ AM ☐ PM ☐ After Snacks ☐ Before Bed ☐ After Breakfast

7. Do you or your child us dental floss in cleaning your child's teeth? ◉ Yes ○ No

   How frequently and when? ☐ AM ☐ PM ☐ After Snacks ☐ Before Bed ☐ After Breakfast

8. Does your child have between meal snacks? ◉ Yes ○ No

9. Have your child's teeth ever been injured?

   When? _____ Which Teeth? _____

   Cause? _____ Were the teeth treated? ○ Yes ○ No

   If so, describe treatment _____

10. Does your child have any of the following habits? (Indicate ages when occurred)

    Bottle to bed at night _____ Tongue thrusting _____

    Thumb or finger sucking _____ Lip sucking or biting _____

    Pacifier _____ Breathes through mouth _____

11. Has your child received any unusual dental or surgical treatment to the mouth? ◉ Yes ○ No

    If so, what _____

Guarantor Information

FATHER'S INFORMATION

Name: _____
Address: _____
Home Phone: _____
Email: _____
Relationship to Patient: _____
Birthday: _____
Social Security Number: _____
Occupation: _____
Employer: _____
Address: _____
Work Phone: (____) _____

Insurance Company Name: _____
Name of Policy Holder: _____
Insurance Company Address: _____
Insurance Company Phone: _____
Group or Plan Number: _____

MOTHER'S INFORMATION:

Name: _____
Address: _____
Home Phone: _____
Email: _____
Relationship to Patient: _____
Birthday: _____
Social Security Number: _____
Occupation: _____
Employer: _____
Address: _____
Work Phone: (____) _____

Insurance Company Name: _____
Name of Policy Holder: _____
Insurance Company Address: _____
Insurance Company Phone: _____
Group or Plan Number: _____

In order to control the cost of dental services, we require that payment Be made at the time of service, unless Otherwise discussed previously with our Financial Coordinator. Payment can be made with cash, personal Check, Master Card or Visa. If for any reason your check is returned to us, there will be an additional fee.

Please indicate the person responsible for payment fees:

Name: _____
Billing Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: (____) _____

Emplyer: _____
Work Phone #: (____) _____
Relationship to Patient: _____

Authorization & Release

CONSENT FOR TREATMENT:

To the best of my knowledge, the questions on this form have been accurately answered. I understand that Providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the Dental office of any changes in my child's medical status. I also authorize the dentist to release any information including the diagnosis and the record of treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners. I authorize the use of radiographs and photographs for the purpose of teaching and scientific publications I request that my insurance company pay directly to the dentist. I understand that my insurance carrier may pay less that the actual bill for services; therefore, I agree to be responsible for payment of all services rendered on my child's behalf.

Signature of Parents/Guardian _____ Date _____

NOTE: Please Download, Fill Out, Save and Email to: info@lrkidsdentist.com