NEW PATIENT- CHILD

Smiles onClark
1108 E. CLARK AVE, STE 160
ORCUTT, CA 93455

1 ABOUT YOUR CHILD

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

Child's Name: _____
LAST FIRST MI

Child's Nickname: _____ OBoy OGirl

Child's Birthdate: _____/_____/_____ Age:_____

School:_____ Grade:_____

Child's Home Phone #: (____) _____

Child's SS#: _____

Child's Address: _____

_____
CITY STATE ZIP

Referred By: _____
(IF DOCTOR, PLEASE GIVE ADDRESS AND PHONE NUMBER)

_____

2 INSURANCE INFORMATION

Primary Dental Insurance-

Company Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (____) _____ Insured's ID#: _____

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

Insured Name: _____

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

Insured's Employer: _____

Secondary Dental Insurance-

Company Name: _____

Address: _____

_____
CITY STATE ZIP

Phone #: (____) _____ Insured's ID#: _____

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

Insured 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? OYes ONo

How many Brothers/Sisters? _____ Age(s): _____ _____ _____

Mother's Name: _____
OSTEP MOTHER OGUARDIAN

_____
(O**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: _____
OSTEP FATHER OGUARDIAN

_____
(O**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 IN EVENT OF EMERGENCY

Person ultimately responsible for account

Name: _____ _____
RELATION TO CHILD

Billing Address: _____

_____
CITY STATE ZIP

_____ ____/____/____ _____
SOCIAL SECURITY # DATE OF BIRTH DRIVERS LIC. #

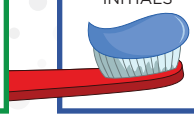
Work Phone#:(____)_____ Cell Phone#:(____)_____
EXT

Payment Method: OCash OCheck

_____ _____/_____
OCredit Card–Enter card # (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)



5 MEDICAL HISTORY

What medications are you taking? O Nerve pills O Stimulants

O Pain killers (including aspirin) O Muscle relaxers O Insulin

O Blood Thinners O Tranquilizers O Meds for Osteoporosis

O Other(s), please list: _____

Have you ever taken:

Bisphosphonates? (ex. Aredia/Fosamax) O Yes O No

Phen-fen/Redux? O Yes O 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 Kidney Problems	Y N Heart Surg./Pacemaker
Y N Shingles	Y N Liver Problems	Y N X-ray or Cobalt Treatment
Y N Heart Murmur	Y N Hepatitis	Y N Jaw Problems TMJ/TMD
Y N Rheumatic Fever	Y N HIV+/AIDS/ARC	Y N Respiratory Problems
Y N Asthma	Y N Sinus Problems	Y N Mitral Valve Prolapse
Y N Heart Disease	Y N Emphysema	Y N Arthritis/ Rheumatism
Y N Difficulty Breathing	Y N Artificial Valves	Y N Stomach Problems/Ulcers
Y N Leukemia	Y N Glaucoma	Y N Artificial Bones/Joints
Y N Chest Pains	Y N Venereal Disease	Y N Diabetes/Hypoglycemia
Y N Psychiatric Problems	Y N Tuberculosis TB	Y N Congenital Heart Defect
Y N Anemia	Y N Alcohol/Drug Abuse	Y N Fainting/Seizures/Epilepsy
Y N Bleeding Problems	Y N Scarlet Fever	Y N Severe/Frequent Headaches
Y N Back Problems	Y N Frequent Neck Pains	Y N High/Low Blood Pressure
Y N Nervousness	Y N Chemotherapy	

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

_____

Are you allergic to any of the following? O Dental Anesthetics

O Latex O Penicillin / Amoxicillin O Tetracycline O Aspirin

O Foods: _____

O Others: _____

Do you use tobacco? O No O Yes/How Used? _____

How Much? _____ How long?_____

Please rate your general health from 1-10: _____

Do you wear contact lenses? O Yes O No

For women: Are you taking Birth Control pills? O Yes O No

How many children have you had?_____

Are you pregnant? O No O Yes/How Long? _____

Are you nursing? O Yes O No

6 DENTAL INFORMATION

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

Are you in pain? O No O Yes How Long? _____

Please indicate any of the following problems:

O Lost/Broken Filling(s) O Stained teeth O Locking Jaw

O Broken/Chipped tooth O Teeth grinding O Ringing in Ears

O Discomfort, clicking or popping in jaw O Bad breath

O Red, swollen or bleeding gums O Blisters/Sores in or around the mouth

O Sensitive tooth, teeth or gums

O Other: _____

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

Previous Dentist:

_____ (_____) _____

NAME PHONE

Last Dental Exam: ___/___/____ Last Dental X-rays: ___/___/_____

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

Type of tooth brush bristles you use? O Soft O Medium O Hard

How would you rate your smile?

(Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

- 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.

Signature: _____ Date: ____/____/_____

O Adult Patient O Parent or Guardian O Spouse

UPDATE
(Office Use)

_____ ____/____/_____ _____ ____/____/_____ _____ ____/____/_____

Initials Date Initials Date Initials Date

_____ _____ _____

Comments Comments Comments