Manhattan Beach
PEDIATRIC DENTISTS
Welcome to the practice!

Date_____

Patient Information

Name: (first & last) _____ Nickname: _____
Birthdate: _____ age: _____ sex: _____
Home Address: _____
City: _____ State: _____ Zip: _____
Home phone: _____

Parent's Marital Status

Married _____ Separated _____ Divorced _____ Single _____ Widowed _____

Father ___ Stepfather ___ Guardian ___

Name: (first & last) _____Birthdate_____
Home Address: (if different than above) _____ _____
Home Phone: __ (_____) _____-_____ Work Phone: __ (_____) _____-_____
Cell Phone: __ (_____) _____-_____ SS#: _____
Employer: _____
Occupation: _____ email address: _____

Mother ___ Stepmother ___ Guardian ___

Name: (first & last) _____Birthdate_____
Home Address: (if different than above) _____ _____
Home Phone: __ (_____) _____-_____ Work Phone: __ (_____) _____-_____
Cell Phone: __ (_____) _____-_____ SS#: _____
Employer: _____
Occupation: _____ email address: _____

Who may we thank for this referral? _____

Primary Dental Insurance

Insured's Name: _____relation to patient: _____
Birthdate: _____ SS# _____
Ins. Company: _____ Group # _____

Additional Insurance

Insured's Name: _____relation to patient: _____
Birthdate: _____ SS# _____
Ins. Company: _____ Group # _____

(over)

Dental History

What would you like for us to do for your child today? _____

Previous Dentist: _____ date of last dental care _____

Has your child ever experienced a mouth or chin injury? _____

Check all that apply: speech difficulty ____ thumb/pacifier habit ____ jaw pain ____ teeth grinding ____ none ____

Other (please specify) _____

Has your child ever experienced an adverse reaction during a dental/medical procedure? No _____ Yes _____

If yes, please explain _____

Other info about your child's previous treatment _____

Medical History

Child's Physician: _____ Address: _____

Has your child had any serious illness or operation? No _____ Yes_____ If so, explain: _____

Has your child ever had a blood transfusion? No _____ Yes_____ if so, approximate date _____

Please check Yes or No to each of the following conditions

Y ____ N ____ Aids/HIV+	Y ____ N ____ Persistent Cough	Y ____ N ____ Kidney Problems
Y ____ N ____ Anemia	Y ____ N ____ Diabetes	Y ____ N ____ Liver Problems
Y ____ N ____ Asthma	Y ____ N ____ Fainting	Y ____ N ____ Digestive Problems
Y ____ N ____ Blood Disease	Y ____ N ____ Respiratory Issues	Y ____ N ____ Skin Rash
Y ____ N ____ Cancer	Y ____ N ____ Abnormal Bleeding	Y ____ N ____ Heart Problems
Y ____ N ____ Chicken Pox	Y ____ N ____ Hearing Impaired	Y ____ N ____ Special Needs
Y ____ N ____ Convulsions/Epilepsy	Y ____ N ____ Brain Injury	Y ____ N ____ Autism
Y ____ N ____ ADD/ADHD	Y ____ N ____ Down's Syndrome	Y ____ N ____ Blindness

Additional comments: _____

_____

List medications your child is taking, if any: _____

_____

Food Allergies: No_____ Yes (please explain) _____

Drug Allergies: No_____ Yes (please explain) _____

Material Allergies (ex.-latex) No_____ Yes (please explain) _____

Consent: I hereby authorize that all necessary dental services be rendered for _____
(Patient's name)

Signature _____ Relationship _____Date _____

Authorization: I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist. I authorize the dentist to release all necessary information to secure payment of benefits.

I am aware that there is a $75 missed appointment fee for cancellation without 24 hour notice.

Signature of person responsible for the account _____

Reviewed by Robyn Fung, DDS. _____