Welcome to Our Practice!

SOUTH BAY PEDIATRIC DENTISTRY

Child's Information

Child's Name (First and Last)_____ Nickname_____

Date of Birth_____ Age_____ Gender_____

Home Address _____

(Street) (City) (Zip)

School_____ Grade_____

Pediatrician _____

_____Mother _____Stepmother _____Guardian _____Other (Please specify) _____

Name_____

Home Phone_____ Cell Phone_____ Work Phone _____

Date of Birth _____

Employer _____

Occupation_____ How Long Held? _____

Social Security or DL# _____ Email Address _____

_____Father _____Stepfather _____Guardian _____Other (Please specify) _____

Name_____

Home Phone_____ Cell Phone_____ Work Phone _____

Date of Birth _____

Employer _____

Occupation_____ How Long Held? _____

Social Security or DL# _____ Email Address _____

Parent's Marital Status: ☐ Married ☐ Domestic Partnership ☐ Separated ☐ Divorced ☐ Single ☐ Widowed

*Responsible Party (If different from parents)

Name_____ Relationship _____

Home Phone_____ Work Phone _____

Date of Birth _____

Employer _____

Occupation_____ How Long Held? _____

Social Security or DL# _____ Email Address _____

Whom may we thank for this referral?

Family or Friend_____ General Dentist_____ Pediatrician _____

Internet_____ Other (Please specifiy) _____

Primary Dental Insurance

Subscriber's Name_____ Relationship to Patient _____

Date of Birth_____ Social Security or ID Number _____

Employer _____

Insurance Company_____ Group # _____

Additional Insurance:

Subscriber's Name_____ Relationship to Patient _____

Date of Birth_____ Social Security or ID Number _____

Employer _____

Insurance Company_____ Group # _____

Date:

Dental History:

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

Previous Dentist_____Date of last dental care _____

May we contact your previous dentist to get copies of your child's previous dental records? ☐ Yes ☐ No

Has your child ever experienced a mouth or chin injury? ☐ Yes ☐ No

Please check all that apply: ☐ Speech Difficulty ☐ Thumb/Pacifier Habit ☐ Jaw Pain ☐ Grinds Teeth

*Other (Please specify) _____

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

* (If yes, please explain) _____

Other information about your child's previous treatment _____

Medical History

Please check all that apply:

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

Additional explanations/comments_____

_____

List medications your child is taking, if any: _____

Food Allergies: _____

Drug Allergies: _____

Material Allergies (ex. Latex): _____

Family Information

Name(s) of Sibling(s)

1:_____Age_____Grade ____

2:_____Age_____Grade ____

3:_____Age_____Grade ____

4:_____Age_____Grade ____

*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 information necessary to secure the payment of benefits.

Payment is due in full at time of treatment, unless prior arrangements have been approved. The difference (if any) between amounts paid by your insurance (where there is an assignment of benefits) and the amount billed is your responsibility.

Charges not paid within 90 days may be subjected to a "late payment" fee of 1.5% per month (18% annual percentage rate) until paid in full. Future services may be refused until the amount outstanding is no longer delinquent. Minimum "late payment" fee is 50 cents.

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

I reviewed a copy of the Notice of Privacy Practices and the Dental Materials Fact Sheet and am aware that copies of both can be made available to me upon request.

Signature of Person Responsible for Account _____

Reviewed by: Nick Brajevich, DDS _____ Date _____