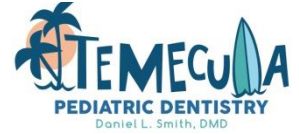


# NEW PATIENT FORM

Please complete all fields below.



## PATIENT INFO

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ M  F

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ M  F

Child's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ M  F

### RESPONSIBLE PARTY INFO

Mother  Stepmother  Legal Guardian

Full Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

SSN \_\_\_\_\_ DOB \_\_\_\_\_

Cell# \_\_\_\_\_

Home# \_\_\_\_\_

Email \_\_\_\_\_

Father  Stepfather  Legal Guardian

Full Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ ST \_\_\_\_\_ ZIP \_\_\_\_\_

SSN \_\_\_\_\_ DOB \_\_\_\_\_

Cell# \_\_\_\_\_

Home# \_\_\_\_\_

Email \_\_\_\_\_

Who can we thank for referring you to us?  
\_\_\_\_\_

## INSURANCE INFORMATION

Do you have dental insurance coverage for your child?

Y  N

Primary Ins. Company \_\_\_\_\_

Subscriber \_\_\_\_\_ DOB \_\_\_\_\_

ID#/SSN \_\_\_\_\_ Group# \_\_\_\_\_

Ins. Phone \_\_\_\_\_

Secondary Ins. Company \_\_\_\_\_

Subscriber \_\_\_\_\_ DOB \_\_\_\_\_

ID#/SSN \_\_\_\_\_ Group# \_\_\_\_\_

Ins. Phone \_\_\_\_\_

## OFFICE POLICIES

**A PARENT OR LEGAL GUARDIAN MUST ACCOMPANY YOUR CHILD ON THIS FIRST VISIT.**

### RESPONSIBLE PARTY POLICY:

Because of a large percent of the population involves a divorce situation, it is our policy to collect from the parent who brings the child in for dental services.

### OFFICE POLICIES:

Unless appointments are canceled at least 24 hours in advance, our policy is to charge \$75 for missed appointments. We do attempt to confirm appointments, but do so only as a courtesy. The Parent/Guardian is responsible for any scheduled appointments made for the child.

I acknowledge that I have read and agree to the above policies:

Signature \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

## PLEASE READ & INITIAL

· I hereby give the dentist permission to complete an oral exam, Radiographs (x-rays) for diagnostic purposes. I understand this visit will include a cleaning and fluoride treatment as well. \_\_\_\_\_

· Payment is due in full for each appointment as services are rendered. If you have dental insurance, we collect your ESTIMATED portion. It is your responsibility to know and understand your individual benefits as every plan is different. \_\_\_\_\_

· This office is not responsible for any insurance company's arbitrary determination of payment, which procedures are covered under the plan, frequency of procedures performed, or period of time taken to process claims. \_\_\_\_\_

· As a courtesy to you, we will complete and file insurance forms relative to dental services and will do our best to collect all fees due to from your insurance carrier; however, fees not paid by your insurance company within 60 days are due and payable by the patient's parent or guardian. \_\_\_\_\_

· I realize that failure to keep this account current may result in the dentist being unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. \_\_\_\_\_

**DANIEL L. SMITH D.M.D**

31560 Rancho Pueblo Rd · Suite 100 · Temecula, CA 92592 · (951) 302-2300 · [www.TemeculaPediatricDentistry.com](http://www.TemeculaPediatricDentistry.com)

## HEALTH HISTORY

Child's Name \_\_\_\_\_ M  F

Grade \_\_\_\_\_ Age \_\_\_\_\_

Child's hobbies/interests \_\_\_\_\_

Child's Pediatrician \_\_\_\_\_

Last Physical \_\_\_\_\_

Is your child under a physician's care now? Y  N

If Yes, reason \_\_\_\_\_

Immunizations up to date? Y  N

Current Medications? Y  N

If Yes, please list \_\_\_\_\_

Allergic to Medication? Y  N

If Yes, please list \_\_\_\_\_

Child have allergic reaction to any of the following?

Latex  Other

If Other, please list \_\_\_\_\_

Has your child ever been a patient in a hospital?  Y  N

If yes, please explain: \_\_\_\_\_

Has your child ever been seen in an emergency room for ANY reason?

Y  N

If Yes, please explain: \_\_\_\_\_

Does your child or anyone in your family have a condition called methylenetetrahydrofolate reductase deficiency (MTHFR) or hyperhomocysteinemia?  Y  N

Has your child had a history or difficulty with any of the following?  None

ADHD/ADD  Ear aches/infections  Physical Disability

Adrenal Disorder  Eating Disorder  Pregnancy

Anxiety  Epilepsy  Premature Birth

Autism  Hearing  Rheumatic Fever

Bladder  Heart  Seizures

Bleeding  Hepatitis  Sinus Problems

Blood Transfusion  HIV/AIDS  Skin Disorder

Bone Disorder  Immune System  Speech Problems

Brain Injury  Intestine/Stomach  Tumors

Bruising  Kidney  Tuberculosis

Cancer  Learning Difficulty  Asthma

Depression  Liver Disease  Last Asthma Attack: \_\_\_\_\_

Diabetes  Lung Disorder \_\_\_\_\_

Down's Syndrome  Other \_\_\_\_\_

If yes to any, please explain: \_\_\_\_\_

\_\_\_\_\_

## DENTAL HISTORY

Is this your child's 1<sup>st</sup> dental visit?  Y  N

If No, previous dentist \_\_\_\_\_

Date of last visit \_\_\_\_\_

How was his/her experience? \_\_\_\_\_

Child's attitude towards the dentist or dental care \_\_\_\_\_

Any injuries to teeth or mouth?  Y  N

Does your child have any of the following habits?

Thumb/Finger  Pacifier  Nail Biting  Lip Sucking

Mouth-breathing  Snoring  Teeth grinding  Nursing

Bottle feeding

Is your water fluoridated?  Y  N

Does your child take fluoride supplements?  Y  N

Does your child use fluoridated toothpaste?  Y  N

How often does your child brush his/her teeth? \_\_\_\_\_x/day

How often does your child floss? \_\_\_\_\_x/day

Reason for your child's visit today \_\_\_\_\_

## DIET HISTORY

Did you or do you breastfeed your child? Y  N

What age did you discontinue breastfeeding? \_\_\_\_\_

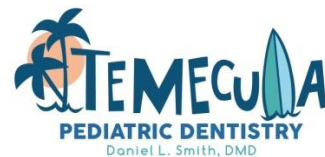
What foods does your child like for a snack? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

What does your child drink on a daily basis? \_\_\_\_\_

\_\_\_\_\_



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