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

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 hyperhomocysteninemia? ☐ 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 1st 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? _____

_____

TEMECULA PEDIATRIC DENTISTRY
Daniel L. Smith, DMD

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