PEDIATRIC DENTISTRY OF PLEASANT HILL

2710 Pleasant Hill Road • Pleasant Hill, CA 94523• 947-1188 • www.phkidsdentist.com

Child's Name _____ Nickname _____ Sex (F) (M) Birthdate _____
First Middle Last

Purpose of visit _____ Concerns _____ Last dental visit_____

Name and age of brothers and sisters_____ Is your child adopted? _____

Child's Interests _____ Name of pet _____

Child's attitude toward previous dental care _____ Any phobias_____

Does your child have any special needs?_____

Child's learning: slow_____ average _____ accelerated _____ Child's previous dentist_____

Family Dentist _____ Who may we thank for referring you to us?_____

Health History

Child's Pediatrician _____ Phone number _____ Last Physical _____

Is your child under a physician's care now?_____ Reason_____ Has your child received all immunizations? _____

Is your child taking any medication or drugs?____ What kind _____ Reason _____

Has your child ever been hospitalized?_____ Reason _____

Is your child allergic to any medications?_____ Please list _____

Does your child have allergic reaction to: eggs_____soy _____foods_____pollen_____dust_____latex_____animals_____other_____

Does your child have any of these habits: finger/thumb sucking_____pacifier_____lip sucking__mouth breathing_____snoring_____teeth grinding_____

Has your child had any injuries to teeth, mouth or head?_____Describe_____

Has your child had a history or difficulty with any of the following:

YES	NO		YES	NO		YES	NO		YES	NO	
____	____	Premature Birth	____	____	Earaches	____	____	Speech Disorder	____	____	Nosebleeds
____	____	Heart	____	____	Kidney	____	____	Hearing	____	____	Asthma
____	____	Seizures	____	____	Bleeding	____	____	Brain injury	____	____	Liver
____	____	Immune disorder	____	____	Cerebral Palsy	____	____	Bruising	____	____	Bone disorder
____	____	Allergy to medication	____	____	Anemia	____	____	Bladder	____	____	Rheumatic fever
____	____	Diabetes	____	____	Motion sickness	____	____	Fainting or dizziness	____	____	Cancer or malignancies
____	____	Hepatitis	____	____	Delayed Development	____	____	Emotional or school problems	____	____	Tuberculosis
____	____	Autism	____	____	ADD/ADHD	____	____	Any medical condition not on this form			

M H REVIEW

How may we help to make this visit a positive experience for your child?_____

_____

GENERAL INFORMATION

Father (full name) _____ SS No. _____ Birthdate _____ Drivers License No._____

Mother (full name) _____ SS No._____ Birthdate_____ Drivers License No._____

Single _____ Married _____ Divorced _____ Child resides with: both parents _____ mother _____ father _____

Home address_____ Phone_____
Street City Zip

Father employed_____ Phone_____
(if self, please state business name)

Business address _____ Cell Phone _____
Street City Zip

Mother employed _____ Phone_____
(if self, please state business name)

Business Address_____ Cell Phone _____
Street City Zip

Email address _____ Person financially responsible for child's dental care_____

Relative not living with you_____
Full Name Street City State Zip Phone

The permission of parent or guardian is necessary for dental treatment of a minor. I give the dentist permission to use such measures as deemed necessary in his/her professional judgement to render the best dental treatment for my child. I understand, a late charge of 1 1/2% per month, or a minimum monthly late charge of $10.00 will be added to unpaid balances over 30 days past due and where appropriate, credit bureau reports may be obtained. Unpaid accounts are subject to collection costs.

SIGNATURE _____ Relationship_____ Date _____

INSURANCE INFORMATION

Do you have dental insurance coverage for this child?_____

Father's Insurance: Name of insurance company_____ Group No. _____

Address of insurance company _____ Zip _____

Mother's Insurance: Name of insurance company_____ Group No._____

Address of insurance company _____ Zip _____

I hereby authorize payment to the above named dentist of the group dental benefits, otherwise payable to me but not to exceed the charges shown on the claim. I understand I am financially responsible for any charges not covered by my insurance or by this authorization.

SIGNATURE _____ RELATIONSHIP_____DATE_____