

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
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____	_____	_____



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 _____ Street _____ City _____ Zip _____ Phone _____

Father employed _____ (if self, please state business name) _____ Phone _____

Business address _____ Street _____ City _____ Zip _____ Cell Phone _____

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

Business Address _____ Street _____ City _____ Zip _____ Cell Phone _____

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 _____