



**Welcome!**

We are pleased to welcome you to our practice. Please fill out this form completely.  
Do not hesitate to ask us if you have any questions.

CONFIDENTIAL PATIENT INFORMATION				
Patient's Last Name:		First:	Middle:	M/F
Street Address:		City:	State:	Zip:
Home Phone:	Birth date:	Social Security #:		
Child prefers to be called:				
CONFIDENTIAL RESPONSIBLE PARTY INFORMATION				
Parent/Guardian Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.
Marital status(circle one) Single/ Mar/ Div/ Sep/ Other				
Home Phone#:	Work Phone#:	Cell Phone#:	Birth date:	Relationship to patient:
Street address: (if different from above)		Social Security #:	E-mail address:	
P.O. Box:	City:	State:	ZIP Code:	
Occupation:	Employer:	Employer Address:	Employer Phone#:	
Parent/Guardian Last Name:		First:	Middle:	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs. <input type="checkbox"/> Miss <input type="checkbox"/> Ms.
Marital status(circle one) Single/ Mar/ Div/ Sep/ Other				
Home Phone#:	Work Phone#:	Cell Phone#:	Birth date:	Relationship to patient:
Address: (if different from above)		Social Security #:	E-mail address:(if different from above)	
Occupation:	Employer:	Employer Address:	Employer Phone#:	
<b>Who can we thank for referring you to our office?</b> (please check applicable boxes if more than one source)				
<input type="checkbox"/> Referred by another office (name): <input type="checkbox"/> Insurance Plan		<input type="checkbox"/> Friend (name): <input type="checkbox"/> Family (name): <input type="checkbox"/> Location: <input type="checkbox"/> Advertisement:		
CONFIDENTIAL INSURANCE INFORMATION				
Is this patient covered by insurance?		<input type="checkbox"/> Y <input type="checkbox"/> N	if yes, does this patient have dual coverage?	
		<input type="checkbox"/> Y <input type="checkbox"/> N		
<b>Name of primary insurance:</b>		Insurance Company Address:		Insurance Co. Phone#:
Subscriber's Name:	Subscriber's ID:	Brith Date:	Group #:	
Patient's relationship to subscriber   Child <input type="checkbox"/> Other <input type="checkbox"/>				
<b>Name of Secondary insurance:</b>		Insurance Company Address:		Insurance Co. Phone#:
Subscriber's Name:	Subscriber's ID:	Brith Date:	Group #:	
Patient's relationship to subscriber   Child <input type="checkbox"/> Other <input type="checkbox"/>				
IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):		Relationship to patient:	Home phone #:	
<p style="text-align: center;"><b>EMAIL CONSENT - I understand I can change my consent at anytime.</b></p> <input type="checkbox"/> I consent and accept the risk in receiving information via email. I consent to receiving appointment reminders via email or text. <input type="checkbox"/> I do not consent receiving any information via email.				
<p>The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the practice. I understand that I am financially responsible for any balance. I also authorize Santa Margarita Pediatric Dentistry and my insurance company to release any information required to process my claims.</p>				
Parent/Guardian Signature:			Date:	

## Patient Health History

Child's Name: Last:	Birth date:
Child's Physician:	
Date of last physical exam:	
Is child under care of physician now? Y N	
Receiving any medications or drugs? Y N	
Ever been hospitalized? Y N	
Ever had surgery? Y N	

### Has child had any history or difficulty with the following? Please circle Yes or No.

Y N A.I.D.S./HIV	Y N Cerebral Palsy	Y N Hay Fever	Y N Mental Disability
Y N Anemia	Y N Cleft Lip/Palate	Y N Hearing Problems	Y N Rheumatic Fever
Y N Bladder Problems	Y N Convulsions	Y N Heart Problems	Y N Sinus Problems
Y N Blood transfusion	Y N Developmental Disability	Y N Hepatitis	Y N Thyroid Disease
Y N Bruise Easily	Y N Diabetes	Y N Jaundice	Y N Tuberculosis
Y N Cancer	Y N Epilepsy	Y N Kidney Disease	Y N Premature
Y N Skeletal problems	Y N Fainting	Y N Liver Disease	Other
Any medications taken?		Has child ever had any asthmatic attacks? Y N	
		If yes, Mild Moderate Severe Frequency?	

Comments:

### Is child allergic to, or ever had an adverse reaction to the following? Please circle Yes or No.

Y N Penicillin	Y N Sedatives	Y N General Anesthesia
Y N Amoxicillin	Y N Sulfa Drugs	Other: (please list)
Y N Local Anesthetics	Y N Latex	

## Dental History

Is this your child's first visit to a dental office? Y N If no, please complete the following:			
Name of previous dentist:		Phone #	
Date of last visit to dentist:		Services received:	
Please (circle) Yes or No to the following questions.			
Has your child had any trouble associated with any previous dental treatment?	Y N	Sensitivity to hot/cold, sweet/sour	Y N
Have you been satisfied with your child's previous dental care?	Y N	Is fluoride taken in any form?	Y N
Does child brush daily?	Y N	Does child suck his/her thumb?	Y N
Does child floss daily?	Y N	Does child use a pacifier or bottle?	Y N
Do gums bleed while brushing or flossing?	Y N	Had orthodontic work?	Y N
Bite lips, cheeks, or nails?	Y N	Experience pain in any teeth?	Y N

The information that I have given is correct to the best of my knowledge. I understand that it will be held the strictest of confidence, and it is my responsibility to inform this office of any changes to my child's medical status. I also understand the use of anesthetic agents embodies a certain risk. I authorize Dr. Jeanne Nguyen and associates to perform all treatment for my above named child and consent to perform the necessary dental services for my child. **I understand that I am financially responsible for all charges whether paid or not by insurance.** I also understand that responsibility for payment for dental services provided in this office for my child is mine, due and payable at the time services are rendered unless financial arrangements have been made IN ADVANCE. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic. I further understand that it is my responsibility to inform this office of any charges in my child's insurance coverage.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE