Riverside Children's Dentistry

Patient Information	Primary Insurance Policy
Patient Name: _____ Last First MI Nickname:_____ Grade :_____ Birth date: _____ Gender: [ ] M [ ] F _____ **Who does the patient live with?** ***Please circle:*** Mother, Father, Grandmother, Grandfather, Aunt, Uncle, Foster Parent/s, Other:_____ ***Information for who/where the patient lives:** Name of Parent/Legal Guardian: _____ Address:_____ City/zip code:_____ Preferred phone #: _____ Email: _____ Preferred method of contact: [ ] phone/text [ ] email Employer:_____ ***Other parent/ legal guardian:** Name: _____ Preferred phone #: _____ Employer:_____ **Who is responsible for this account?** _____ **How did you hear about us?** _____ *OFFICE USE ONLY:* Dental history: _____ _____ Next visit: right / left FM recall P.O. check:_____ N2O Behavior Management G.A. (time) _____	Relationship to subscriber: [ ] Self [ ] Spouse [ ] Child Subscriber name: _____ Insurance company: _____ Subscriber ID # : _____ Subscriber DOB:_____ Group name : _____ Group #: _____ Employer: _____ _____ **Secondary Insurance Policy** Relationship to subscriber: [ ] Self [ ] Spouse [ ] Child Subscriber name: _____ Insurance company: _____ Subscriber ID # : _____ Subscriber DOB:_____ Group name : _____ Group #: _____ Employer: _____ _____

MEDICAL HISTORY

Pediatrician / Primary Care Physician: _____ Phone number:_____ City: _____ Medical Specialist: _____ _____ Phone number: _____ City: _____	Emergency contact: _____ Phone number: _____ Relationship: _____ **Has your child ever had surgery or been hospitalized for any reason? [ ] Y [ ] N** **If so, please explain:** _____ _____ _____

Is your child taking any medications? [ ] Y [ ] N Please list them here: _____ _____ _____ _____ Is your child taking any pain medicine or antibiotics now? [ ] Y [ ] N If so, what medications? _____ Does your child need antibiotics/pre-med before dental treatment? [ ] Y [ ] N [ ] dont know	Is your child allergic to any of the following? Anesthetic.....[ ] Y [ ] N Aspirin.....[ ] Y [ ] N Codeine.....[ ] Y [ ] N Ibuprofen..... [ ] Y [ ] N Iodine..... [ ] Y [ ] N Latex..... [ ] Y [ ] N Penicillin/Amoxicillin..... [ ] Y [ ] N Sulfa..... [ ] Y [ ] N Food Allergies.....[ ] Y [ ] N please list:_____ Other:_____

Conditions:	Y	N		Y	N
ADD/ADHD			Hay Fever/Seasonal Allergies		
Anemia			Hearing Problems		
Asthma			Heart Murmur		
Autism			Heart Trouble/Disease/Surgery		
Autoimmune Disease/ Lupus			Hepatitis Type:_____		
Bleeding Problems/ Hemophilia			High Blood Pressure		
Bisphosphonate Therapy/ Steroids			HIV		
Cancer/Leukemia/Chemo,Radiation			Joint Replacement		
Cerebral Palsy			Liver Disease		
Cleft lip/Cleft Palate			Metal pins, screws or implants		
Developmental Delay			Neutropenia		
Diabetes Type I or Type II			Organ Transplant		
Down Syndrome			Orthopedic Surgery		
Eye Problems			Prosthesis		
Epilepsy/Seizures			Physical Disability		

Psychiatric Treatment	Y	N	Stroke	Y	N
Rheumatic Fever			Snoring/Sleep Apnea		
Sickle Cell Anemia/Trait or Disease			Tuberculosis		
Sinus Trouble			Vascular Catheter/ Vascular Shunts		
Special Health Care Need			Gastrointestinal/ GI Tube		
Speech Delay			Spina Bifida		
Other:			Other:		

DENTAL HISTORY

Name of Former/ Referring Dentist: **NONE [ ]** _____ City:_____ Phone number:_____ Date of last exam/X-rays:_____ Date of last cleaning:_____	Reason for today's visit:_____ _____ _____ Is your child in pain?_____ If so, where and for how long?_____ _____ _____
Past dental experience: **NONE [ ]** Treatment with: (*mark all that apply*) Local Anesthetic_____ Laughing Gas (Nitrous Oxide)_____ Oral Sedation_____ Physical Restraint_____ IV/General Anesthesia_____ Overall Behavior: [ ] cooperative [ ] uncooperative	How many times does your child: Brush?_____per day Floss? _____per day Do you help your child with brushing and flossing at home? [ ] Y [ ] N Does your child use fluoridated: Toothpaste [ ] Y [ ] N Mouthwash/rinse [ ] Y [ ] N Has patient received treatment with:(mark all that apply) Orthodontist: _____ Oral Surgeon : _____ Endodontist : _____

Oral Habits	Y	N		Y	N
Is child nursing?			Does child have a nail biting habit?		
Does child drink from a bottle?			Does child have a tongue thrust habit?		
Does child drink from a sippy cup?			**Patient drinks:**		
Does child suck his/her thumb/finger?			Water, ***please circle****:* bottled or tap?		
Does child use a pacifier?			Milk, ***please circle***: plain or flavored?		
Does child grind his/her teeth?			Fruit juice		
Does child suck on his/her lip?			Soda, sports drinks, juice boxes/pouches?		

Age your child stopped nursing:
Age your child stopped the bottle:
Age your child stopped using sippy cups:

Riverside Children's Dentistry
4960 Arlington Ave, Suite A
Riverside, CA 92504
951-977-9992

Patient Name:_____

Please read the consent form and ask about any procedure you do not understand. As a legal guardian, I consent to the following treatment done for my child:

Preventative Treatment:

__X__ Exam __X__ X-rays __X__ Cleaning __X__ Fluoride Treatment

Initials _____ Date _____

Financial Agreement

* For my convenience, this office may release my information to my insurance company, and receive payment directly from them.
* I understand that if I begin major treatment that involves lab work, I will be responsible for the fee at that time.
* If sent to collections, I agree to pay all related fees and court costs.
*Every effort will be made to help me with my insurance, but if they do not pay as expected, I will still be responsible.
*Treatment plans may change and I will be responsible for the work actually done.

*** Your appointment is subject to cancellation if you do not confirm by the end of business day prior to your scheduled appointment.**

*** I will pay a $25 fee for appointments broken without 24 hours notice.**

_____

Signature of Parent/ Legal Guardian **Date**

Acknowledgment of Receipt of Notice of Privacy Practices

I have received a copy of Lil Smile Builders Children's Dentistry:

1. Notice of Privacy Policies
2. Copy of Dental Materials Fact Sheet

Print Name: _____

Signature: _____ **Date :** _____

If this acknowledgment is signed by a personal representative on behalf of the patient, complete the following:

Relationship to patient: _____

I certify that I have reviewed these forms:

_____ _____

Witness **Date** **Dentist** **Date**