EL CAMINO DENTAL ARTS

GET - ACQUAINTED QUESTIONNAIRE

THIS INFORMATION IS IMPORTANT FOR OUR RECORDS
AND FOR YOUR CHILD'S HEALTH
AND WILL BE KEPT CONFIDENTIAL

PURPOSE OF VISIT

If for pain, where is the pain? _____ duration _____

Whom may we thank for referring you to our office? _____

GENERAL INFORMATION

Name of patient _____ Sex ____ Age _____ Birthdate _____

Residence address _____ City _____ Zip _____

Residence phone _____ Contact Email _____

Father's name _____ Occupation _____ Date of Birth _____

Employer _____ Social Security Number _____

Business address _____ Work /cell # _____

Mother's name _____ Occupation _____ Date of Birth _____

Employer _____ Social Security Number _____

Business address _____ Work /cell # _____

Is child covered by dental insurance? YES ❍ NO ❍

Primary Insurance Name _____ Claims Tel.# _____ Group #: _____

Secondary Insurance Name _____ Claims Tel.# _____ Group #: _____

IN CASE OF EMERGENCY, CONTACT _____
Name *Home Tel.#* *Work Tel.#*

MEDICAL HISTORY

Name of physician _____ City _____ Phone _____

Has child been under the care of a physician during the past two years, besides for routine check up? YES ❍ NO ❍

If yes, for what? _____

Is child currently taking any medication? If so, what kind? _____

	YES	NO
Is child in good health?	❍	❍
Does child have history of rheumatic fever, heart murmur, mitral valve prolapse?	❍	❍
Is child subject to prolonged bleeding?	❍	❍
Does child have history of heart trouble, diabetes, TB, asthma, epilepsy, liver or kidney involvement?	❍	❍
Does child have a history of blood trouble, anemia, leukemia?	❍	❍
Does child have any other medical problems?	❍	❍

if YES, what? _____

	YES	NO
Does your child need to be pre-medicated before dental treatment?	❍	❍
Human Immunodeficiency Virus (H.I.V.)?	❍	❍
Does child have history of hepatitis?	❍	❍
Is child subject to any nervous disorders, fainting or dizziness?	❍	❍
Does child have history of allergies?	❍	❍
Does child have any sinus problems?	❍	❍
Does child have difficulty breathing? (while sleeping)	❍	❍
Does child have frequent sore throat?	❍	❍
Has child ever experienced any allergic reaction to Novocaine, Penicillin or any other drug?	❍	❍

Please specify _____

HEALTH HISTORY UPDATE

Date			
Changes			
Initials			

(CONTINUED ON REVERSE SIDE)

DENTAL HISTORY

Is this child's first dental visit? YES ❍ NO ❍

if NO, name of previous dentist_____

Date of last visit_____what was done at that time?_____

Are you dissatisfied with your child's teeth or their appearance? YES ❍ NO ❍

if YES, what concerns you the most?_____

Has child experienced an unfavorable reaction from any previous dental treatment? YES ❍ NO ❍

if YES, what?_____

Has child had speech correction? YES ❍ NO ❍

Does child have any of the following oral habits?

❍ Thumb or finger sucking ❍ Grinding or clenching of teeth

❍ Mouthbreathing ❍ Lip or nail biting

❍ Other

Serious injuries to the face, head or teeth? YES ❍ NO ❍

if YES, nature and location of injury _____

PLEASE INQUIRE ABOUT ANY QUESTIONS WHICH ARE NOT UNDERSTOOD
CONSENT OF TREATMENT

The administration and monitoring of general anesthesia may vary depending on the type of procedure the type of practitioner, the age and health of the patient and the setting in which anesthesia is provided. Risks may vary with each specific situation. You are encouraged to explore all the options available for child's anesthesia for his or her dental treatment and consult with your dentist or pediatrician as needed (B&P 1682).

I do authorize and give consent to the doctor and his staff to administer treatment, including, but not limited to, local anesthesia, analgesia and other such treatment which may be necessary for the above named patient. I also understand that the use of these agents and some procedures embodies a certain risk. I further state that the above medical and dental history was completed fully and accurately to the best of my knowledge.

PATIENT OR GUARDIAN SIGN NAME DATE

PATIENT RESPOSIBLE FOR FEES & ASSIGMENT OF INSURANCE BENEFITS: I understand that responsibility for payment for Dental Services provided in this office for myself or my dependent is mine. Unless prior special arrangements are made, accounts are to be paid on date which services are provided. I hereby authorize that the payment from any insurance company due me be paid directly to this office. In the event of default in payment, patient or party responsible for fees agrees to pay any and all cost of suit, collection and attorney's fees.

24 HOUR CANCELLATION NOTICE PREVENTS A $50 BROKEN APPOINTMENT FEE.

_____

Signature – Patient or Responsible Party