# Jade Miller, DDS

# **Pediatric Dentristy**

# Gilbert A Trujillo, DDS

### **Patient Information**

| Who may we thank for referring you?  |                           |                               |   |         | Date://                               |
|--|---------------------------|-------------------------------|---|---------|---------------------------------------|
| Nick Name:   |                           | Bir                           | rthdate//   | Age_    | Sex: M F                              |
| Child's Name:  |                           |                               |   |         |                                       |
| First M.I.   |                           | Last                          |   |         |                                       |
| Your child's interests/sports  |                           |                               |   |         |                                       |
| School   |                           | Gra                           | ade   |         |                                       |
| Has our office previously seen any siblings? Yes No  |                           | Pet                           | 58  |         |                                       |
| Name/Age of child's Brothers   |                           | Sisters                       |   |         |                                       |
|  |                           | l Information                 |   |         |                                       |
| Is this your child's first dental visit? Y N   | Previous                  | s Dentist                     |   |         | Last visit                            |
| How do expect your child to react to this visit? How many times a day does your child brush? How many times a day does your child floss? Does your child have any of the following habits (p | Excellen                  |                               | Fair Po<br>Is your child assist<br>Is your child assist | ed? Y   | Unsure<br>N                           |
| 1. Finger sucking 2. Tongue Thrusting  | 3. Mouth<br>4.Teeth G     |                               | <ul><li>5. Thumb sucking</li><li>6. Pacifier</li></ul>  |         |                                       |
| Does your child receive fluoride from (please circle) 1. Vitamins 2. Water supply  | 3. Tooth                  |                               | 5. Tablets/Drops Do                                     | sage    |                                       |
| Was your child bottle fed? Y N Until what age?_<br>Has your child had any toothaches recently? Y N   | Br                        | east fed? Y N<br>ease explain | Until what age?   |         |                                       |
| Has your child ever had any injuries to the mouth, jaw,  | teeth or hea              |                               | Please describe   |         | · · · · · · · · · · · · · · · · · · · |
| Has your child had a bad experience in another dental of<br>Do you have any specific concerns or questions you woul  |                           | cuss?                         | Please describe   |         |                                       |
|  |                           | al Information                |   |         |                                       |
| Child's Physician  |                           |                               | _   | of last | exam                                  |
| Child's Specialists  |                           |                               |   | of last | exam                                  |
| Is your child in good health? Y N Is your child presently being treated for any condi Has your child been hospitalized or had surgery (i Please explain                                      | ition? Y N<br>including o | Please<br>ut-patient surge    | ery)? Y N   |         |                                       |
| Is your child currently taking any medications? Y<br>Has your child experienced or is there a family his<br>Describe the problem   | story of and              | esthetic related              | problems including r                                    |         | ant hyperthermia? Y N                 |
| What family member was affected, and what is th  | e relations               | hip to your child             | d   |         |                                       |
| Has your child ever been c   | diagnosed w               | ith any of the follo          | wing? (Please circle )                                  | es or N | lo to each)                           |
| No Yes ADD w/ Hyperactivity  |                           | Cleft Lip/Palate              |   |         | Heart Murmur                          |
| No Yes ADD w/o Hyperactivity No Yes AIDS   |                           | Convulsions/Seizu<br>Diabetes |   |         | Hepatitis<br>Kidney Disease           |
| No Yes Anemia  |                           | Emotional Distur              |   |         | Leukemia                              |
| No Yes Asthma  | No Yes                    | Traumatic Experi              | ience N   |         | Liver Disease                         |
| No Yes Autism  |                           | Excessive Bleedin             | _   |         | Mental Retardation                    |
| No Yes Birth Defects   |                           | Bleeding Disorder             |   |         | Nutritional Deficiency                |
| No Yes Blood Transfusions No Yes Bone/Joint Problems   |                           | Excessive Gaggin Eye Problems |   |         | Oral Ulcers<br>Orthopedic Problems    |
| No Yes Brain Injury  |                           | Fainting/Dizzines             |   |         | Premature Birth                       |
| No Yes Bruising Easily   |                           | Growth/Developm               |   | o Yes   | Rheumatic Fever                       |
| No Yes Cancer/Malignancies   |                           | Hearing Problems              |   |         | Scoliosis                             |
| No Yes Cerebal Palsy   |                           | Ear Infections                | N   | o Yes   | Speech Problems                       |
| No Yes Chronic Headaches   | No Yes                    | Heart Disease                 |   |         | Tuberculosis<br>Other:                |
| To any <b>YES</b> answers above, please explain:   |                           |                               |   |         |                                       |
| Please circle if your child is allergic to any of  | f the follo               | wing:                         |   |         |                                       |
| Penicillin   | I.e                       | ıtex                          | Other: (please list)                                    |         |                                       |
| Amoxicillin  |                           | ollen/Dust                    | Omer. (piease iist)                                     |         |                                       |
| Modications (places list)  |                           | od Allergies/Dye              | og (plagge ligt)  |         |                                       |

### **Family Information**

| Appointments can be made by (please circle): Mom Dad Both Natural Parents Guardian(s)  PLEASE NOTE: If Legal Guardians are NOT the natural parents, we must have current cop of court papers for our records.  Emergency Contact (Specify someone who does not live in your household.)  Family (or close friend) Name:  Cell Phone:  Relationship to Patient  Address:  Primary Dental Insurance  Insurance Name Phone #  Group/Policy #  Mailling address  Subscriber's Name  Subscriber's Employer Subscriber's S\$# or Id#  Secondary Dental Insurance  Insurance Name Phone #  Group/Policy #  Mailling address Subscriber's Birthdate  Phone #  Group/Policy #  Mailling address Subscriber's Name  Subscriber's Name  Subscriber's Employer Subscriber's S\$# or Id# Subscriber's Birthdate  AUTHORITY TO TREAT / TERMS, CONDITIONS AND FINANCIAL INFORMATION  I hereby authorize Jade Miller DDS and/or Gilbert A Trujillo DDS to treat the above patient using restorative and patient management technique that are acceptable and proper. I understand that at treatment plan with associated fees will be discussed fully with the parent / guardian prior the beginning of any treatment. I also understand that the treatment plan and fees could change depending upon the time elapsed since the intil examination or as a result of radiographic results not obtained at the initial examination. In addition. In addition. In addition. In addition and the initial examination or as a result untorize release of this information to the patient's medical doctor of record. Dental insurance is an agreement between my family's insurance carrier and the policy holder. I authoric payment directly to the dentilist. I agree to accept responsibility for the full payment of service, regardless of insurance benefits; therefore, I recognit statements will come to me, at my address. I also understand that this office will only send statements to me, and cannot be involved in third par situations. I acknowledge the above information is true and correct.                                       | Mother's Name  |  |   |  | В   | irthdate//   |  |
|--|--|--|---|--|---|--|--|
| Street/FO Box  | Relationship of the Mother to the child (pleas   | e circle) Natural  | I   | Step-mo  | ther Guard  | ian (relation)   |  |
| Birthdate   Birt         | Mailing address  |  |   |  |   |  |  |
| Employer Occupation  Email Addross Brather's Name Birthdate f / Robationship of the Father to the child (please circle) Natural Step-father Guardian (relation) Delta didress Street/PO Box City State Zip Code  Home phone ( ) Work phone ( ) Cell ph       |  | -  |   |  | -   |  |  |
| Email Address  |  |  |   |  |   |  |  |
| Email Address  Father's Name   |  |  |   | cupation   |   |  |  |
| Relationship of the Pather to the child (please circle)  |  |  |   |  |   |  |  |
| Relationship of the Father to the child (please circle) Natural Step-father Guardian (relation)  Mailing address  Street/PO Box City State Zip Code  Home phone ( ) Cell ph       | Email Address  |  |   |  |   |  |  |
| Mailing address  Street/PO Box  City  State  Zip Code  Home phone (  | Father's Name  |  |   |  | Bir   | thdate//   |  |
| Street/FO Box  | Relationship of the Father to the child (please  | e circle) Natural  |   | Step-fat   | her Guard   | ian (relation)   |  |
| Street/FO Box  | Mailing address  |  |   |  |   |  |  |
| Employer Occupation  Social Security Number   Email Address  Legal Custody is with (please circle): Mom Dad Both Natural Parents Guardian(s) Child lives with: (please circle): Mom Dad Both Natural Parents Guardian(s) Natural parents marital status (please circle): Mom Dad Both Natural Parents Guardian(s) Natural parents marital status (please circle): Mom Dad Both Natural Parents Guardian(s)  PLEASE NOTE: If Legal Guardians are NOT the natural parents, we must have current cop of court papers for our records.  Emergency Contact (Specify someone who does not live in your household.) Family (or close friend) Name:  Cell Phone:  Address:  Primary Dental Insurance  Insurance Name Phone # Group/Policy #  Mailing address Subscriber's S\$# or Id# Subscriber's Birthdate // Secondary Dental Insurance  Insurance Name Phone # Group/Policy #  Mailing address Subscriber's Employer Subscriber's S\$# or Id# Subscriber's Birthdate // Subscriber's Birthdate // Subscriber's Employer Subscriber's S\$# or Id# Subscriber's Birthdate // Subscriber's Sirthdate // Subscriber's Employer Subscriber's S\$# or Id# Subscriber's Birthdate // Subscriber's Employer Subscriber's S\$# or Id# Subscriber's Birthdate // Subscriber's Employer Subscriber's S\$# or Id# Subscriber's Birthdate // Subscriber's Employer Subscriber's Employer Subscriber's S\$# or Id# Subscriber's Birthdate // Subscriber's Employer |  | City   | Sta   | te   | Zip Code  |  |  |
| Social Security Number   Email Address   | Home phone ()  | Work phone (   | ()  |  | Cell p  | hone ()  |  |
| Legal Custody is with (please circle):   Mom   Dad   Both   Natural   Parents   Guardian(s)  | Employer   |  | Oc  | cupation   |   |  |  |
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| Natural parents marital status (please circle): Married Single/Never Married Separated Divorced Widowe Appointments can be made by (please circle): Mom Dad Both Natural Parents Guardian(s)  PLEASE NOTE: If Legal Guardians are NOT the natural parents, we must have current cop of court papers for our records.  Emergency Contact (Specify someone who does not live in your household.)  Family (or close friend) Name:   | Legal Custody is with (please circle):   | Mom  | Dad   | Both   | Natural Parents   | Guardian(s)  |  |
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| Emergency Contact (Specify someone who does not live in your household.)  Family (or close friend) Name:   | Appointments can be made by (picase circle).   | IVIOIII  | Dau   | Doni <u>maturar</u>  | Tarents Gu  | artifari(s)  |  |
| Primary Dental Insurance  Insurance Name   | Family (or close friend) Name:   | ·<br>  |   |  |   |  |  |
| Insurance Name Phone # Group/Policy #  |  |  |   |  |   |  |  |
| Subscriber's Employer Subscriber's S\$# or Id# Subscriber's Birthdate/   |  | Primary D  | Dental Insi   | ırance   |   |  |  |
| Subscriber's Employer Subscriber's S\$# or Id# Subscriber's Birthdate/   | Insurance Name Pho   | one #  |   | Group/   | Policy #  |  |  |
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| Mailing address Subscriber's Name Subscriber's Employer Subscriber's S\$# or Id# Subscriber's Birthdate/   |  | -  |   |  |   |  |  |
| Subscriber's Employer Subscriber's S\$# or Id# Subscriber's Birthdate/   |  |  |   | * *  |   |  |  |
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|  | A LITHODITY TO TD  |  |   |  | ber's Birthdate   | //   |  |
| Signature of Parent / Guardian Date Date Relation to Patient   | I hereby authorize Jade Miller DDS and/or Gilber that are acceptable and proper. I understand that the beginning of any treatment. I also understand examination or as a result of radiographic results patient's medical doctor of record. Dental insura payment directly to the dentist. I agree to accept restatements will come to me, at my address. I also | REAT / TERMS, CONTENT A Trujillo DDS to the attreatment plan with that the treatment protoble obtained at the increase is an agreement exponsibility for the funderstand that this | NDITIONS A<br>treat the above<br>ith associated<br>plan and fees<br>initial examir<br>to between my<br>full payment | ND FINANCIA<br>re patient using<br>I fees will be dis<br>could change of<br>nation. In addit<br>y family's insur-<br>of service, regar | ber's Birthdate  AL INFORMATION  restorative and particussed fully with the lepending upon the ion, I authorize relevance carrier and the dless of insurance by | tient management techniques he parent / guardian prior to time elapsed since the initial case of this information to the policy holder. I authorize benefits; therefore, I recognize |  |