Jade Miller, DDS **Pediatric Dentristy** **Gilbert A Trujillo, DDS**

Patient Information

Who may we thank for referring you?_____ Date:___/___/_____

Nick Name:_____ Birthdate___/___/____ Age____ Sex: M F

Child's Name:_____
First M.I. Last

Your child's interests/sports_____

School_____ Grade_____

Has our office previously seen any siblings? Yes No Pets_____

Name/Age of child's Brothers_____ Sisters_____

Dental Information

Is this your child's first dental visit? Y N Previous Dentist_____ Last visit_____
How do expect your child to react to this visit? Excellent Good Fair Poor Unsure
How many times a day does your child brush? _____ Is your child assisted? Y N
How many times a day does your child floss? _____ Is your child assisted? Y N
Does your child have any of the following habits (please circle)
1. Finger sucking 3. Mouth Breather 5. Thumb sucking
2. Tongue Thrusting 4.Teeth Grinding 6. Pacifier
Does your child receive fluoride from (please circle)
1. Vitamins 3. Toothpaste 5. Tablets/Drops Dosage_____
2. Water supply 4. Rinse/Gel
Was your child bottle fed? Y N Until what age?_____ Breast fed? Y N Until what age?_____
Has your child had any toothaches recently? Y N Please explain_____
Has your child ever had any injuries to the mouth, jaw, teeth or head? Y N Please describe_____
Has your child had a bad experience in another dental office? Y N Please describe_____
Do you have any specific concerns or questions you would like to discuss? _____

Medical Information

Child's Physician_____ Date of last exam_____
Child's Specialists_____ Date of last exam_____
Is your child in good health? Y N Are your child's immunizations up to date? Y N
Is your child presently being treated for any condition? Y N Please explain_____
Has your child been hospitalized or had surgery (including out-patient surgery)? Y N
Please explain_____

_____

Is your child currently taking any medications? Y N Please list_____
Has your child experienced or is there a family history of anesthetic related problems including malignant hyperthermia? Y N
Describe the problem_____
What family member was affected, and what is the relationship to your child_____

Has your child ever been diagnosed with any of the following? (Please **circle** Yes or No to each)

No Yes ADD w/ Hyperactivity
No Yes ADD w/o Hyperactivity
No Yes AIDS
No Yes Anemia
No Yes Asthma
No Yes Autism
No Yes Birth Defects
No Yes Blood Transfusions
No Yes Bone/Joint Problems
No Yes Brain Injury
No Yes Bruising Easily
No Yes Cancer/Malignancies
No Yes Cerebal Palsy
No Yes Chronic Headaches
No Yes Cleft Lip/Palate
No Yes Convulsions/Seizures
No Yes Diabetes
No Yes Emotional Disturbance
No Yes Traumatic Experience
No Yes Excessive Bleeding
No Yes Bleeding Disorder
No Yes Excessive Gagging
No Yes Eye Problems
No Yes Fainting/Dizziness
No Yes Growth/Development problems
No Yes Hearing Problems
No Yes Ear Infections
No Yes Heart Disease
No Yes Heart Murmur
No Yes Hepatitis
No Yes Kidney Disease
No Yes Leukemia
No Yes Liver Disease
No Yes Mental Retardation
No Yes Nutritional Deficiency
No Yes Oral Ulcers
No Yes Orthopedic Problems
No Yes Premature Birth
No Yes Rheumatic Fever
No Yes Scoliosis
No Yes Speech Problems
No Yes Tuberculosis
No Yes Other:_____

To any **YES** answers above, please explain:_____

Please circle if your child is allergic to any of the following:

Penicillin Latex Other: **(please list)** _____
Amoxicillin Pollen/Dust
Medications **(please list)**_____ Food Allergies/Dyes **(please list)**_____

Family Information

Mother's Name_____ Birthdate___/___/_____
Relationship of the Mother to the child (please circle) Natural Step-mother Guardian (relation) _____

Mailing address_____
Street/PO Box City State Zip Code

Home phone (___) _____ Work phone (___)_____ Cell phone (___)_____

Employer_____ Occupation_____

Social Security Number _____

Email Address _____

Father's Name_____ Birthdate___/___/_____

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 (___)_____ Work phone (___)_____ Cell phone (___)_____

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): Married Single/Never Married Separated Divorced Widowed
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 copies of court papers for our records.

Emergency Contact (Specify someone who **does not live** in your household.)
Family (or close friend) Name:_____ Phone:_____
Cell Phone:_____ Relationship to Patient_____
Address:_____

Primary Dental Insurance

Insurance Name_____ Phone #_____ Group/Policy #_____
Mailing address_____ Subscriber's Name _____
Subscriber's Employer_____ Subscriber's SS# or Id#_____ Subscriber's Birthdate _____/_____/_____

Secondary Dental Insurance

Insurance Name_____ Phone #_____ Group/Policy #_____
Mailing address_____ Subscriber's Name _____
Subscriber's Employer_____ Subscriber's SS# 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 techniques that are acceptable and proper. I understand that a treatment plan with associated fees will be discussed fully with the parent / guardian prior to the beginning of any treatment. I also understand that the treatment plan and fees could change depending upon the time elapsed since the initial examination or as a result of radiographic results not obtained at the initial examination. In addition, I authorize 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 authorize payment directly to the dentist. I agree to accept responsibility for the full payment of service, regardless of insurance benefits; therefore, I recognize 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 party situations. I acknowledge the above information is true and correct.

Signature of Parent / Guardian _____ Date _____ Relation to Patient _____