

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

To any YES answers above, please explain: _____

Do biological parents and/or grandparents have a history of any of the above? No Yes If yes please explain: _____

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

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

Family Information

Parent/Guardian _____ Birthdate ____/____/____
Relationship to the child (please circle) Mother/Father Step-Mother/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 _____

Parent/Guardian _____ Birthdate ____/____/____
Relationship to the child (please circle) Mother/Father Step-Mother/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 Parents Guardian(s)
Child lives with: (please circle): Mom Dad Both Parents Guardian(s)
Parent/Guardian marital status (please circle): Married Single Separated Divorced Widowed

If Legal Guardians are NOT the parents, we require copy of current court documentation 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 Gilbert A Trujillo DDS and/or Kellie McGinley DDS and/or Jade Miller 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 be mailed 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 _____
Print name Parent/Guardian _____