



We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in creating your beautiful smile!

**Patient Information**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Age: \_\_\_\_  
Nickname: \_\_\_\_\_ Male: \_\_\_\_ Female: \_\_\_\_ Social Security: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_  
Home Telephone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Whom May We Thank For Your Referral: \_\_\_\_\_  
Patient's Dentist: \_\_\_\_\_ Last Check-up/Cleaning: \_\_\_\_/\_\_\_\_/\_\_\_\_

**Responsible Party Information**

Mother/Guardian Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Social Security: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Employer: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_  
Home Telephone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Work: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Cell: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Email: \_\_\_\_\_

Father/Guardian Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Social Security: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Employer: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_  
Home Telephone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Work: \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Cell: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Email: \_\_\_\_\_

**Primary Insurance Coverage**

Primary Insured Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship to Patient: \_\_\_\_\_ Social Security: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Name of Insurance: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

**Secondary Insurance Coverage**

Secondary Insured Name: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Relationship of Patient: \_\_\_\_\_ Social Security: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Employer: \_\_\_\_\_ Address: \_\_\_\_\_  
Name of Insurance: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Address: \_\_\_\_\_ Telephone: \_\_\_\_ - \_\_\_\_ - \_\_\_\_

## Health History

Purpose of today's dental examination? \_\_\_\_\_

### Personal

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Nickname(if any) \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_

Is your child adopted?  Yes  No If yes, does your child know?  Yes  No

Physician's Name \_\_\_\_\_ Telephone \_\_\_\_\_

Family Dentist \_\_\_\_\_ Name of child's school \_\_\_\_\_

### Medical History

- |   |  |   |
|---|--|---|
| <input type="radio"/> Yes <input type="radio"/> No AIDS/HIV                     | <input type="radio"/> Yes <input type="radio"/> No Cleft Lip/Palate    | <input type="radio"/> Yes <input type="radio"/> No Kidney Disease       |
| <input type="radio"/> Yes <input type="radio"/> No Allergies to latex           | <input type="radio"/> Yes <input type="radio"/> No Developmental Delay | <input type="radio"/> Yes <input type="radio"/> No Liver Disease        |
| <input type="radio"/> Yes <input type="radio"/> No Anemia                       | <input type="radio"/> Yes <input type="radio"/> No Diabetes            | <input type="radio"/> Yes <input type="radio"/> No Rheumatic Fever      |
| <input type="radio"/> Yes <input type="radio"/> No ADD/ADHD                     | <input type="radio"/> Yes <input type="radio"/> No Epilepsy            | <input type="radio"/> Yes <input type="radio"/> No Sinus Problems       |
| <input type="radio"/> Yes <input type="radio"/> No Bladder Problems             | <input type="radio"/> Yes <input type="radio"/> No Heart Problems      | <input type="radio"/> Yes <input type="radio"/> No Thyroid Disease      |
| <input type="radio"/> Yes <input type="radio"/> No Cancer                       | <input type="radio"/> Yes <input type="radio"/> No Hepatitis           | <input type="radio"/> Yes <input type="radio"/> No Trauma to mouth/face |
| <input type="radio"/> Yes <input type="radio"/> No Cerebral Palsy               | <input type="radio"/> Yes <input type="radio"/> No Jaundice            | <input type="radio"/> Yes <input type="radio"/> No Tuberculosis         |
| <input type="radio"/> Yes <input type="radio"/> No Premature                    | <input type="radio"/> Yes <input type="radio"/> No Stomach problems    | <input type="radio"/> Yes <input type="radio"/> No Blood Disorders      |
| <input type="radio"/> Yes <input type="radio"/> No Hospital stays or operations |  |   |

Other \_\_\_\_\_

Is your child currently taking any medication?  Yes  No If yes, list names and purpose \_\_\_\_\_

Does your child have any breathing problems?  Yes  No

Breathes primary through:  Nose  Mouth Does your child snore?  Yes  No

Is your child taking any supplemental fluoride?  Tablets  Drops  Water  Vitamins

### Allergic or reactions to any of the following? Please Circle

Aspirin \_\_\_\_\_ Local Anesthetics \_\_\_\_\_ Sulfa Drugs \_\_\_\_\_  
Antibiotics \_\_\_\_\_ Metal \_\_\_\_\_ Barbiturates Sedatives \_\_\_\_\_

Other: \_\_\_\_\_

### Habits

Child have any of the following habits?

Yes  No Thumb or Finger sucking  Yes  No Nail biting  Yes  No Teeth grinding

Yes  No Pacifier use  Yes  No Biting or sucking lip

Did your child use a bottle?  Yes  No If yes, when did child stop? \_\_\_\_\_

Does your child currently use a bottle?  Yes  No If yes, how often during the day? \_\_\_\_\_

### Family Dental History

Mother \_\_\_ Father \_\_\_ had a lot of decay Mother \_\_\_ Father \_\_\_ had orthodontic care

Mother \_\_\_ Father \_\_\_ have periodontal disease Mother \_\_\_ Father \_\_\_ have TMJ problems

### Child's Dental History

Has child seen a dentist before?  Yes  No If yes, approximate date of last visit \_\_\_\_\_

Where? \_\_\_\_\_

Unfavorable experiences in a dental or medical office?  Yes  No

if yes, please explain: \_\_\_\_\_

How often does your child brush teeth? \_\_\_\_\_ Do you help?  Yes  No

How often does your child floss? \_\_\_\_\_ Do you help?  Yes  No

### Authorization

The information that I have given is correct to the best of my knowledge. I understand that I will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my child. I certify that the patient is covered by insurance with :\_\_\_\_\_. I assign directly to **Torrey Pines Pediatric Dentistry** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that responsibility for payment for dental services provided in the office for my child is mine, due and payable at the time services are rendered unless financial arrangements have been made IN ADVANCE. I hereby authorize **Torrey Pines Pediatric Dentistry** to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions, whether manual or electronic. I further understand that is my responsibility to inform this office of any changes in my child's insurance coverage.



## PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
2. Obtaining payment from third payers (e.g. my insurance company)
3. The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date \_\_\_\_\_

Print Patient Name: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Print Name of Parent/Guardian: \_\_\_\_\_

Signature of Parent/Guardian: \_\_\_\_\_