Date_____

PATIENT INFORMATION

Patient Name: _____ Nick Name:_____

Birthday: _____ Age:_____ Grade:_____ Sex: ☐ Male ☐ Female

School:_____ Names & ages of siblings: _____

Home Phone:_____ Cell Phone:_____ Work Phone:_____ Email:_____

Home Address: _____
street *city, state* *zip code*

Who has legal custody of patient?_____

Father's / Guardian's Name_____ SS#_____DOB_____

Mother's / Guardian's Name _____ SS#_____DOB_____

Whom may we thank for referring you to us? _____

What is the reason for your child's dental visit?_____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact? (Someone not living with you)

Name_____ Relationship_____ Phone_____

Name_____ Relationship_____ Phone_____

HEALTH HISTORY

☐ Yes ☐ No Is your child in good health? Date of last physical exam_____

Name of child's physician _____ Phone_____

☐ Yes ☐ No Has your child ever had a health problem? _____

☐ Yes ☐ No Has your child ever been hospitalized or had surgery?

Please give reason and dates _____

☐ Yes ☐ No Is there excessive bleeding when cut?

☐ Yes ☐ No Is your child **allergic** to anything? If so, what?_____

☐ Yes ☐ No Is your child currently taking any medications?

Please give medication and reason _____

☐ Yes ☐ No Were there any problems at birth?_____

Please check if your child has been treated for any of the following:

☐ Yes ☐ No Heart disease	☐ Yes ☐ No Congenital birth defects	☐ Yes ☐ No Mental delays
☐ Yes ☐ No Liver/GI disease	☐ Yes ☐ No Recurrent headaches	☐ Yes ☐ No Physical delays
☐ Yes ☐ No Kidney disease	☐ Yes ☐ No Asthma	☐ Yes ☐ No Thyroid disease
☐ Yes ☐ No Speech/hearing	☐ Yes ☐ No Diabetes	☐ Yes ☐ No Drug/Alcohol abuse
☐ Yes ☐ No Cerebral palsy	☐ Yes ☐ No Hepatitis	☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Cancer/tumors	☐ Yes ☐ No Cleft lip/palate	☐ Yes ☐ No Bladder diff
☐ Yes ☐ No Bleeding/ transfusions	☐ Yes ☐ No Personality/social	☐ Yes ☐ No Chicken Pox
☐ Yes ☐ No Anemia	☐ Yes ☐ No Strep throat	☐ Yes ☐ No Measles/Mumps
☐ Yes ☐ No Rheumatic fever	☐ Yes ☐ No Blood dyscrasias	☐ Yes ☐ No Other problems
☐ Yes ☐ No Seizures/Epilepsy	☐ Yes ☐ No AIDS/HIV	

Please explain any items checked: _____

DENTAL HISTORY

☐ Yes ☐ No Has your child ever had a dental visit?

Name of dentist and date _____

☐ Yes ☐ No Has your child experienced any unfavorable reaction from previous dental care?

Explain _____

☐ Yes ☐ No Does your child suck a finger, thumb or pacifier?

☐ Yes ☐ No Does your child have pain with chewing, yawning, or wide opening?

☐ Yes ☐ No Does your child breathe mainly through the mouth?

☐ Yes ☐ No Does your child grind his / her teeth?

☐ Yes ☐ No Does your child snore?

Please check if your child is having problems with any of the following:

☐ Cavities	☐ Toothache	☐ Teeth Sensitive
☐ Trauma	☐ Gum Infections	☐ Color of Teeth
☐ Orthodontics	☐ Jaw Sounds	☐ Other

Comments: _____

INSURANCE COMPANY

Insurance Company _____ Group # _____

Subscriber Name _____ Subscriber's DOB _____

Subscriber's SS # _____ Relationship to Patient _____

Is patient covered by additional insurance? ☐ Yes ☐ No

Insurance Company _____ Group # _____

Subscriber Name _____ Subscriber's DOB _____

Subscriber's SS # _____ Relationship to Patient _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign payment directly to doctor. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____

Responsible Party Signature Relationship Date

CONSENT FOR DENTAL TREATMENT

I request and authorize Dr. Hirano, or any other doctor at Kidz Dental Care, to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Hirano / Staff to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic, educational, or marketing purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Hirano / Staff will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, using variable voice tone and stabilization with a pedowrap. I will be responsible for any charges incurred on this child for dental treatment.

I understand that collection actions may be taken if my balance goes beyond 90 days.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

Parent/Guardian Signature _____ Date _____