

Children's Dentistry of Walnut Creek



Patient Information

First name: _____ Last name: _____
Middle Initial: _____ Preferred Name _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: () _____ Cellular: () _____
Sex: Male Female Birth Date: _____ Age: _____
Student Status: Full Time Part Time School Name: _____
Physicians Name: _____ Phone _____
Kaiser Medical #: _____ Doctor: _____
Preferred Pharmacy: _____ City: _____ Phone: _____
Who may we thank for referring you to our office: _____

Responsible Party

Name: _____ Relationship to Patient: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: () _____ Work Phone: () _____ Cellular: () _____
Birth Date: _____ Social Security: _____ Drivers License: _____
 Responsible Party is also a Policy Holder for Patient Primary Insurance Policy Holder Secondary Insurance Policy Holder

Primary Insurance Information

Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Other
Insured S/S#: _____	Insured Birthdate: _____
Employer: _____	Ins Company: _____
Address: _____	Address: _____
City State Zip: _____	City State Zip: _____

Secondary Insurance Information

Name of Insured: _____	Relationship to Patient: <input type="checkbox"/> Father <input type="checkbox"/> Mother <input type="checkbox"/> Guardian <input type="checkbox"/> Other
Insured S/S#: _____	Insured Birthdate: _____
Employer: _____	Ins Company: _____
Address: _____	Address: _____
City State Zip: _____	City State Zip: _____

TERMS AND CONDITIONS

I hereby authorize payment directly to **Children's Dentistry of Walnut Creek** of the group insurance benefits otherwise payable to me. I understand that responsibility for payment of services provided in this office is mine, regardless of insurance involvement.

Date: _____ Responsible Party Signature: _____

Medical History

Is the patient under a physician's care now? Yes No If yes, please explain: _____
Is the patient in good health? Yes No If no, please explain: _____
Has the patient ever been hospitalized or had a major operation? Yes No If yes, please explain: _____

Is the patient taking any medications, pills, or drugs? Yes No If yes, please explain: _____

Has the patient taken Phen-Fen or Redux? Yes No _____

Is the patient on a special diet? Yes No _____

Does the patient premedicate with antibiotics prior to dental appointments? Yes No If yes, what do you take? _____ Has the patient ever had an unfavorable reaction after dental treatment? Yes No

Other allergies not listed? _____

Is the patient allergic to any of the following?

Penicillin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Valium	<input type="checkbox"/> Yes <input type="checkbox"/> No	Local Anesthetics	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tetracycline	<input type="checkbox"/> Yes <input type="checkbox"/> No	Percodan	<input type="checkbox"/> Yes <input type="checkbox"/> No	Bleach	<input type="checkbox"/> Yes <input type="checkbox"/> No
Erythromycin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Codeine	<input type="checkbox"/> Yes <input type="checkbox"/> No	Household cleaners	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sulfa	<input type="checkbox"/> Yes <input type="checkbox"/> No	Vicodin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Disinfectants	<input type="checkbox"/> Yes <input type="checkbox"/> No
Aspirin	<input type="checkbox"/> Yes <input type="checkbox"/> No	Cloves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Acrylic	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ibuprofen/Advil	<input type="checkbox"/> Yes <input type="checkbox"/> No	Latex	<input type="checkbox"/> Yes <input type="checkbox"/> No	Metal	<input type="checkbox"/> Yes <input type="checkbox"/> No

Does the patient have any of the following?

AIDS/HIV Positive	<input type="checkbox"/> Yes <input type="checkbox"/> No	Frequent Diarrhea	<input type="checkbox"/> Yes <input type="checkbox"/> No	Psychiatric Care	<input type="checkbox"/> Yes <input type="checkbox"/> No
Abnormal Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Handicaps/Disabilities	<input type="checkbox"/> Yes <input type="checkbox"/> No	Radiation Treatments	<input type="checkbox"/> Yes <input type="checkbox"/> No
ADD/ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Impairment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recent Weight Gain/Loss	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hemophilia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Rheumatic Fever	<input type="checkbox"/> Yes <input type="checkbox"/> No
Artificial, Joints/Valves	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No	Sickle Cell Disease/Trait	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Special Needs/Disabilities	<input type="checkbox"/> Yes <input type="checkbox"/> No
Chemotherapy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hives or Rash	<input type="checkbox"/> Yes <input type="checkbox"/> No	Spina Bifida	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions/Epilepsy	<input type="checkbox"/> Yes <input type="checkbox"/> No	Operations	<input type="checkbox"/> Yes <input type="checkbox"/> No	Stomach/Intestinal Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cold Sores	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hypoglycemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	Swelling of Limbs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	Low Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Epilepsy or Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No	Mitral Valve Prolapse	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tonsillitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting Spells/Dizziness	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive Bleeding	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tuberculosis (TB)	<input type="checkbox"/> Yes <input type="checkbox"/> No
Frequent Cough	<input type="checkbox"/> Yes <input type="checkbox"/> No	Pain Jaw Joints	<input type="checkbox"/> Yes <input type="checkbox"/> No	Tumors or Growths	<input type="checkbox"/> Yes <input type="checkbox"/> No
				Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No

Have they ever had any illness not listed above? Yes No If yes, please explain: _____

Does/did the patient have any of the following habits?

Lip Sucking/Biting Yes No Nail Biting Yes No Nursing/Bottle Habits Yes No
Thumb/Finger sucking Yes No Pacifier Habits Yes No

CONSENT FOR EXAMINATION

I hereby consent to allow the **Doctors and Staff of Children's Dentistry of Walnut Creek** to obtain adequate information to diagnose the patient's dental condition. This may include an **initial examination**, the production of **radiographs (X-Rays)**, performing diagnostic **tests**, and **communicating** with other healthcare providers involved in my treatment. The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

Date: _____ Responsible Party Signature: _____