



FULLERTON
PEDIATRIC DENTISTRY

Welcome Forms

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventative care. We strive to teach proper oral health care that will enable your child to have a beautiful smile that lasts a lifetime. The information requested below is very important and becomes apart of our permanent records.

Tell Us About Your Child:

Today's Date: _____

Name: _____

Nickname: _____

Birth Date: _____

Age: _____ **Gender:** Male / Female

Home Address: _____

School: _____ **Grade:** _____

Name/Age of Siblings: _____

Siblings Seen by Us That Child Live With?

Adopted? Y/N

Who can we thank for referring you?

Health History

Child's Physician: _____ Phone: (____) _____

Date of last visit: _____ Address: _____

Is your child currently under the care of a physician? ☐ Yes ☐ No

Please explain: _____

Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor

Are Immunizations Current? Yes No

Please list all medications and dosage that your child is currently taking:

Please list all drugs and/or things that cause your child allergic reactions:

Has your child had/experienced any of the following: (please circle)

Y <input type="checkbox"/> N <input type="checkbox"/> Abnormal Bleeding	Y <input type="checkbox"/> N <input type="checkbox"/> Endocrine System Disorders	Y <input type="checkbox"/> N <input type="checkbox"/> Mitral Valve Prolapse
Y <input type="checkbox"/> N <input type="checkbox"/> AIDS/HIV+	Y <input type="checkbox"/> N <input type="checkbox"/> Epilepsy	Y <input type="checkbox"/> N <input type="checkbox"/> Mononucleosis
Y <input type="checkbox"/> N <input type="checkbox"/> Allergies	Y <input type="checkbox"/> N <input type="checkbox"/> Frequent Infections	Y <input type="checkbox"/> N <input type="checkbox"/> Rheumatic Fever
Y <input type="checkbox"/> N <input type="checkbox"/> Anemia	Y <input type="checkbox"/> N <input type="checkbox"/> Handicaps: _____	Y <input type="checkbox"/> N <input type="checkbox"/> Recurrent Headaches
Y <input type="checkbox"/> N <input type="checkbox"/> Any Hospital Stays		Frequency: _____
Y <input type="checkbox"/> N <input type="checkbox"/> Any Operations	Y <input type="checkbox"/> N <input type="checkbox"/> Hearing Impaired	Y <input type="checkbox"/> N <input type="checkbox"/> Scarlet Fever
Y <input type="checkbox"/> N <input type="checkbox"/> Asthma	Y <input type="checkbox"/> N <input type="checkbox"/> Heart Murmur	Y <input type="checkbox"/> N <input type="checkbox"/> Seizures
Y <input type="checkbox"/> N <input type="checkbox"/> Behavior/Learning/Disabilities	Y <input type="checkbox"/> N <input type="checkbox"/> Hemophilia	Y <input type="checkbox"/> N <input type="checkbox"/> Sickle Cell Anemia
Y <input type="checkbox"/> N <input type="checkbox"/> Blood Dyscrasia	Y <input type="checkbox"/> N <input type="checkbox"/> Hepatitis	Y <input type="checkbox"/> N <input type="checkbox"/> Sight Disorder
Y <input type="checkbox"/> N <input type="checkbox"/> Blood Transfusion	Y <input type="checkbox"/> N <input type="checkbox"/> High Blood Pressure	Y <input type="checkbox"/> N <input type="checkbox"/> Significant Injuries
Date: _____	Y <input type="checkbox"/> N <input type="checkbox"/> Hives	Y <input type="checkbox"/> N <input type="checkbox"/> List: _____
Y <input type="checkbox"/> N <input type="checkbox"/> Breathing/Lung Problems	Y <input type="checkbox"/> N <input type="checkbox"/> Kidney Problem	_____
Y <input type="checkbox"/> N <input type="checkbox"/> Cancer Tumor	Y <input type="checkbox"/> N <input type="checkbox"/> Liver/CI System Problems	_____
Y <input type="checkbox"/> N <input type="checkbox"/> Chicken Pox	Y <input type="checkbox"/> N <input type="checkbox"/> Low Blood Pressure	_____
Y <input type="checkbox"/> N <input type="checkbox"/> Congenital Birth Defect	Y <input type="checkbox"/> N <input type="checkbox"/> Lupus	Y <input type="checkbox"/> N <input type="checkbox"/> Skin Rash
Y <input type="checkbox"/> N <input type="checkbox"/> Congenital Birth Disease	Y <input type="checkbox"/> N <input type="checkbox"/> Measles	Y <input type="checkbox"/> N <input type="checkbox"/> Tonsillitis
Y <input type="checkbox"/> N <input type="checkbox"/> Diabetes	Y <input type="checkbox"/> N <input type="checkbox"/> Mentally Physically Disabled	Y <input type="checkbox"/> N <input type="checkbox"/> Tuberculosis (TB)

1. Has your child ever been hospitalized? Yes ☐ No ☐

If so, when? _____ For what reason? _____

2. Has your child had any operations? Yes No

If so, when? _____ For what reason? _____

3. Does your child bruise easily? Yes No

4. Has there ever been any history of spontaneous bleeding (e.g., nose bleeds) or prolonged bleeding following tooth removal surgery, cuts, etc.? Yes No

REMARKS:

Dental History

1. Please check reason(s) for seeking dental care

First Examination ☐

Routine check-up ☐

Toothache or swelling ☐

Other _____

Dental History ☐

Appearance of teeth or face ☐

Crowding Teeth Accident ☐

2. If your child has been to a dentist previously? ☐ Yes ☐ No

a. When was the last visit? _____

b. Have x-rays been taken and when? ☐ Yes ☐ No Date: _____

c. How would you describe your child's temperament? _____

3. How do you think your child would react to dental treatment? _____

4. Has your child had fluoride in any of the following forms?

Fluoride tablets or in vitamins (Fluoride amt. .25 .5 1.0 mg) ☐ Yes ☐ No

Drinking water (community fluoridation) ☐ Yes ☐ No

Topical application to teeth? ☐ Yes ☐ No When is last _____

Toothpaste; brand _____

5. Does your child brush his/her own teeth? ☐ Yes ☐ No

How frequently and when? A.M. P.M. After Snacks Before Bed After Breakfast

6. Do you brush your child's teeth? ☐ Yes ☐ No

How frequently and when? A.M. P.M. After Snacks Before Bed After Breakfast

7. Do you or your child use dental floss in cleaning your child's teeth? ☐ Yes ☐ No

How frequently and when? A.M. P.M. After Snacks Before Bed After Breakfast

8. Does your child have between meal snacks ☐ Yes ☐ No

9. Have your child's teeth ever been injured?

When? _____ Which Teeth? _____

Cause? _____

Were the teeth treated? ☐ Yes ☐ No

If so, describe the treatment _____

10. Does your child have any of the following habits? (Indicate ages when occurred)

Bottle to bed at night _____

Thumb or finger sucking _____

Pacifier _____

Tongue thrusting _____

Lip sucking or biting _____

Breathes through mouth _____

11. Has your child received any unusual dental or surgical treatment to the mouth? ☐ Yes ☐ No

If so, what _____

Guarantor Information

FATHER'S INFORMATION

Name: _____
Home Phone: _____
Relationship to Patient: _____
Birthday: _____
Social Security Number: _____
Occupation: _____
Employer: _____
Address: _____
Work Phone: (____) _____
Email Address: _____

Insurance Company Name: _____
Name of Policy Holder: _____
Insurance Company Address: _____
Insurance Company Phone: _____
Group or Plan Number: _____

MOTHER'S INFORMATION

Name: _____
Home Phone: _____
Relationship to Patient: _____
Birthday: _____
Social Security Number: _____
Occupation: _____
Employer: _____
Address: _____
Work Phone: (____) _____
Email Address: _____

Insurance Company Name: _____
Name of Policy Holder: _____
Insurance Company Address: _____
Insurance Company Phone: _____
Group or Plan Number: _____

In order to control the cost of dental services, we require that payment be made at the time of service, unless otherwise discussed previously with our Financial Coordinator. Payment can be made with cash, personal check, MasterCard or Visa. If for any reason your check is returned to us, there will be an additional fee.

Please indicate the person responsible for payment fees:

Name: _____
Billing Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: (____) _____

Employer: _____
Work Phone #: (____) _____
Relationship to Patient: _____

Authorization & Release

CONSENT FOR TREATMENT

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or health practitioners. I authorize the use of radiographs and photographs for the purpose of teaching and scientific publications. I request that my insurance company pay directly to the dentist. I understand that my insurance carrier may pay less than the actual bill for services; therefore, I agree to be responsible for payment of all services rendered on my child's behalf.

Signature of Parents/Guardian _____ Date: _____

Note: Please Download, Fill Out, Save and Email to: mail@fullertonpediatricdentists.com