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 N Abnormal Bleeding	Y N Endocrine System Disorders	Y N Mitral Vavle Prolapse
Y N AIDS/HIV+	Y N Epilepsy	Y N Mononucleosis
Y N Allergies	Y N Frequent Infections	Y N Rheumatic Fever
Y N Anemia	Y N Handicaps:_____	Y N Recurrent Headaches
Y N Any Hospital Stays	_____	Frequency:_____
Y N Any Operations	Y N Hearing Impaired	Y N Scarlet Fever
Y N Asthma	Y N Heart Murmur	Y N Seizures
Y N Behavior/Learning/Dissabilities	Y N Hemophilia	Y N Sickle Cell Anemia
Y N Blood Dyscrasis	Y N Hepatitis	Y N Sight Disorder
Y N Blood Transfusion	Y N High Blood Pressure	Y N Significant Injuries
Date:_____	Y N Hives	Y N List:_____
Y N Breathing/Lung Problems	Y N Kidney Problem	_____
Y N Cancer Tumor	Y N Liver/CI System Problems	_____
Y N Chicken Pox	Y N Low Blood Pressure	_____
Y N Congenital Birth Defect	Y N Lupus	Y N Skin Rash
Y N Congenital Birth Disease	Y N Measles	Y N Tonsilitis
Y N Diabetes	Y N Mentally Physically Disabled	Y N 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 ☐ Dental History ☐
Routine check-up ☐ Appearance of teeth or face ☐
Toothache or swelling ☐ Crowding Teeth Accident ☐
Other _____

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 undstand 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: fpd5437@gmail.com