sebastopol DENTAL CARE

120 Pleasant Hill Avenue N #110
Sebastopol, CA 95472
707.823.6481

CHILD REGISTRATION FORM

Patient Name_____ Date of Birth_____ SSN# _____

Home Phone_____ Person Financially Responsible _____

Home Address (Street, City, Zip) _____

Guardian Name_____ Relationship to patient _____

Guardian Phone # _____ SSN# _____ Email _____

Will someone other than a legal guardian accompany patient to appointments? ☐**Yes**☐**No**

How did you hear about us? _____

I. MEDICAL HISTORY

1. ☐Yes☐No Has child gone to the hospital or emergency room or had a serious illness in the last three years?
2. ☐Yes☐No Is child being treated by a physician now? Physician name: _____
   Date of last medical exam:_____ Reason for exam: _____
3. ☐Yes☐No Has child ever taken bisphosphonate medications (Eg. Fosamax)?
4. ☐Yes☐No Does child have allergies to medications, latex, or metal?
   If YES to any question, explain: _____
5. ☐Yes☐No Is there any issue or condition that you would like to discuss with the dentist in private?
6. ☐Yes☐No Is child currently taking any medications? List: _____

II. HAS YOUR CHILD EVER HAD OR HAVE ANY OF THE FOLLOWING? (Please circle Yes or No for each)

☐Yes☐No Heart disease	☐Yes☐No AIDS/HIV	☐Yes☐No Psychiatric care
☐Yes☐No Surgeries	☐Yes☐No Heart attack	☐Yes☐No Hospitalization
☐Yes☐No Thyroid disease	☐Yes☐No Artificial joint	☐Yes☐No Diabetes
☐Yes☐No Asthma	☐Yes☐No Stomach problems or ulcers	☐Yes☐No Family history of diabetes
☐Yes☐No Hepatitis	☐Yes☐No Heart defects	☐Yes☐No Tumors or cancer
☐Yes☐No Sexual transmitted disease	☐Yes☐No Heart murmurs	☐Yes☐No Chemotherapy
☐Yes☐No Herpes	☐Yes☐No Rheumatic fever	☐Yes☐No Radiation
☐Yes☐No Canker or cold sores	☐Yes☐No Skin disease	☐Yes☐No Arthritis, rheumatism
☐Yes☐No Anemia	☐Yes☐No Emphysema/other lung disease	☐Yes☐No Liver disease
☐Yes☐No High blood pressure	☐Yes☐No Kidney or bladder disease	☐Yes☐No Eye disease
☐Yes☐No Seizures	☐Yes☐No Stroke	☐Yes☐No Transplants
☐Yes☐No Eating disorders	☐Yes☐No Tuberculosis	☐Yes☐No Acid Reflux

Other: _____

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform the dentist of any change in my child's health and/or medication. Further, I will not hold the dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Parent Name: _____ **Date:** _____

Parent Signature: _____ **Dentist Signature:** _____

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CHILD DENTAL HISTORY

Patient Name _____ Date of Birth_____

Date of last dental visit _____ Reason for last visit _____

Previous Dentist _____

If you left your previous dentist, what was the reason? _____

What is the reason for your visit today? _____

Has your child:		If Yes, explain:
1. Complained about any dental problems or pain?	**Yes/No**	_____
2. Had any unhappy dental experiences?	**Yes/No**	_____
3. Had any injuries to mouth, teeth or head?	**Yes/No**	_____
4. Lost any teeth from trauma?	**Yes/No**	_____
5. Had any missing teeth replaced?	**Yes/No**	_____
6. Had orthodontic treatment either now or in the past?	**Yes/No**	_____
7. Ever been premedicated for dental treatment?	**Yes/No**	_____
Does your child:		**If Yes, explain:**
8. Have any mouth habits such as thumb sucking, nail biting, mouth breathing, nursing bottle habits, pacifier use, etc?	**Yes/No**	_____
9. Have any unusual speech habits?	**Yes/No**	_____
10. Brush his/her teeth daily?	**Yes/No**	How many times a day?_____
11. Receive help from a parent when brushing?	**Yes/No**	
12. Use an electric toothbrush?	**Yes/No**	
13. Use a fluoride toothpaste?	**Yes/No**	
14. Floss his/her teeth regularly?	**Yes/No**	
15. Grind his/her teeth?	**Yes/No**	
16. Want or need orthodontic treatment?	**Yes/No**	If Yes, why?_____

I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful dental history and that the dentist and his/her staff will rely on this information for treating my child. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction.

Parent Name: _____ **Date:** _____

Parent Signature: _____ **Dentist Signature:** _____

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WELCOME TO OUR OFFICE

We believe that communication with our patients regarding our policies assists us in providing the best quality service to you.

APPOINTMENTS

We reserve the doctor and hygienist's time on the schedule for each patient procedure and are diligent about being on time. Because of this courtesy, when a patient cancels an appointment, it affects the overall quality of service we are able to provide.

If you are unable to keep your scheduled appointment we must have a ***minimum of 2 business days' notice*** to reschedule an appointment. With less than 2 business days notice, ***$50*** or a deposit to reserve the appointment time again, may be required. We appreciate your consideration regarding this policy. **Initial:** _____

INSURANCE

If you have insurance, please let us know. We work with most dental insurers. Policies vary, but we will try to help you get the most benefits from your particular policy. We will be happy to prepare a claim and mail it for you. Please keep in mind that you are responsible for your total obligation should your insurance benefits result in less coverage than anticipated. Your estimated portion is due at each visit. We recommend that you become familiar with your insurance benefits as it is your responsibility to know your benefits.

PAYMENT

Payment is due at the time services are rendered. As stated above, if you have insurance, your estimated co-payment is due. If you do not have insurance the entire amount is due at time of service, unless you have made prior financial arrangements with our office.

PARENT/PATIENT AUTHORIZATIONS AND ACKNOWLEDGEMENTS

I understand that the information I have given today is correct to the best of my knowledge. I authorize this dental team to perform any necessary dental services for my child that I have consented to during diagnosis and treatment.

I authorize the release of information necessary to process my dental benefit claims. I hereby authorize payment directly to this doctor otherwise payable to me.

I hereby acknowledge that a copy of this practice's *Notice of Privacy Practices* has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

I hereby acknowledge that a copy of this practice's *Dental Materials Fact Sheet* has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Fact Sheet.

Patient Name: _____

Parent Name: _____

Parent Signature: _____ Date: _____