Welcome

to our practice! We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

We confirm all appointments via email. If you do not have email, we will confirm by phone.

Email_____

Raul Perez, DDS

Orthodontics and Dentistry for Kids

Your Child

Child's First _____

M.I.___ Last_____

Preferred _____ Sex _____

Date of Birth _____ Age ____

SS# _____

Child's Home Address_____

_____

City _____

State/Prov. _____

ZIP _____

Phone _____

☐ Mother

☐ Stepmother ☐ Guardian

First_____ M.I.___

Last_____

Home Phone_____

Work Phone_____

Cell Phone _____

SS#_____

Date of Birth_____

Employer_____

Occupation_____

DL#_____

☐ Father

☐ Stepfather ☐ Guardian

First_____ M.I.___

Last_____

Home Phone_____

Work Phone_____

Cell Phone _____

SS#_____

Date of Birth_____

Employer_____

Occupation_____

DL#_____

Dental Insurance

Insured's name_____ Relationship_____

Date of Birth_____ SS#_____ Employer_____

Ins. Company_____ Group #_____ ID#_____

Nearest Relative

First _____ M.I. ____

Last _____

Relationship _____

Address _____

_____

Home Phone _____

Work Phone_____ Ext._____

Cell Phone_____

Parent's Marital Status

☐Single ☐Divorced

☐Married ☐Widowed

☐Separated

How did you hear about us?

_____

CLEAR FORM

Medical History

Your child's overall health as well as any medications which your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Has your child ever had any of the following:

Asthma ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No
HIV/AIDS ☐ Yes ☐ No
Hemophilia ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Allergies ☐ Yes ☐ No
Autism ☐ Yes ☐ No
Respiratory Disease ☐ Yes ☐ No
Stomach or Intestinal Disease ☐ Yes ☐ No

Rheumatic Fever ☐ Yes ☐ No
Congenital Heart Defect ☐ Yes ☐ No
Handicaps/Disabilities ☐ Yes ☐ No
Convulsions/Epilepsy ☐ Yes ☐ No
Abnormal Bleeding ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No
ADHD/ADD ☐ Yes ☐ No
Kidney Disease ☐ Yes ☐ No
Any Blood Disease ☐ Yes ☐ No

Previous Surgeries ☐ Yes ☐ No (if yes, what and when?)

_____

Please explain any medical problems that your child has

_____

Please list any medications your child may be taking_____

Please list anything your child may be allergic to_____

Dental History

How often does your child brush? _____

How often does your child floss? _____

Date of last dental visit _____

Previous Dentist _____

Child's Physician _____

Physician's Number _____

Has your child had difficulty with previous visits? _____

Is your child's water fluoridated? ..... ☐ Yes ☐No

Does your child take fluoride supplements? ..... ☐ Yes ☐ No

Does your child:

Suck Thumb/finger ..... ☐ Yes ☐ No

Suck/bite lips ..... ☐ Yes ☐ No

Bite/Chew Nails ..... ☐ Yes ☐ No

Chew Hard Objects (pencils, etc.)..... ☐ Yes ☐ No

Grind teeth ..... ☐ Yes ☐ No

Clench Jaws ..... ☐ Yes ☐ No

Office use

Medical Alert: _____

_____

_____

Hx: _____

_____

_____

Authorization and Release

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 authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependants.

X_____

Signature of parent or legal guardian, if minor

_____

Date

RECERTIFICATION: I certify that there have been no changes in my child's health except as noted below:

DATE	CHANGE	SIGNATURE