The benefits of a happy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health. Please fill out this form completely. The better we communicate, the better we can care for you.

Milpitas Dental Center

"We've got Milpitas Smiling"

Tell Us About Your Child

Today's Date: _____

Child's Name: _____ Nickname: _____ ☐ Male ☐ Female
Last First Mi

Birthday: ____/____/____ Child's Age: _____ Social Security #: _____ Home Phone #: (____) _____

Child's Home Address: _____
Street City State Zip

School: _____ Grade: _____

Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous/ Present Dentist: _____ Last visit date: _____
(Please circle)

Person Responsible For Account

His/Her Name _____ Relation: _____ Work Phone #: (____) _____ Home Phone #: (____) _____

Birthday: ____/____/____ Social Security#: _____

Address: _____
Street City State Zip

Mother's Information

Name: _____ ☐Step Mother ☐Guardian

Birthday: ____/____/____ Social Security #: _____ Home Phone #: (____) _____

Employer: _____ Work Phone #: (____) _____ Ext: _____

Insurance Co. Name: _____ Phone #: (____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/ PO Box City State Zi

Father's Information

Name: _____ ☐Step Father ☐Guardian

Birthday: ____/____/____ Social Security #: _____ Home Phone #: (____) _____

Employer: _____ Work Phone #: (____) _____ Ext: _____

Insurance Co. Name: _____ Phone #: (____) _____ Group # (Plan, Local or Policy #): _____

Insurance Co. Address: _____
Street/ PO Box City State Zi

Dental History

Is this your child's first visit to the dentist? ☐ Yes ☐ No

If not, how long since the last visit to the dentist? _____

Why did you bring the child to the dentist today? _____

_____

Has the child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

If yes, please explain _____

Has the child ever had any pains/ tenderness in his or her jaw joint (TMJ/ TMD) ? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Does the child brush his/ her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Have there been any injuries to the teeth, face, or mouth? ☐ Yes ☐ No

If yes, please explain _____

Child's Physician: _____

Phone #: (___)_____ Date of last visit: _____

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

Your child's current physical health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs that the child is currently taking: _____

_____

Please list all drugs that the child is allergic to: _____

_____

Medical History

Has the child ever experienced the following?

Y N Allergies to Latex
Y N Abnormal Bleeding
Y N Allergies to any Drugs
Y N Any Hospital Stays
Y N Any Operations

Y N Asthma
Y N Cancer
Y N Congenital Heart Defect
Y N Convulsions/Epilepsy
Y N Diabetes

Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis

Y N HIV/ AIDS
Y N Kidney Problems
Y N Liver Disease
Y N Rheumatic/ Scarlet Fever
Y N Tuberculosis (TB)

Please discuss any serious problems that the child has had: _____

_____

Does the child have any of the following habits?

Y N Lip Sucking/ Biting | Y N Nail Biting | Y N Nursing Bottle Habits | Y N Thumb/ Finger Sucking

Authorization

I affirm that the information I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform the necessary services I may need. I assign the Doctor all insurance benefits. I understand that I am responsible for payment of services rendered, any deductible, and co-payment that my insurance does not cover.

_____
Signature Date

I understand photos taken of my teeth, smile, or portrait may be displayed for patient educational purposes.

_____
Signature Date

For Office Use Only

I verbally reviewed the medical/ dental information above with Parent/ guardian and patient named herein.
Initials _____ Date _____

Insurance Verification: **Effective Date**

Preventive _____% Deductible $ _____

Basic _____% Maximum $ _____

Major _____%

Doctor's Comments _____

_____

_____

Does insurance cover sealants (1351) ? ☐ Yes ☐ No

If yes, what do they fall under? _____

Ortho Coverage ☐ Yes ☐ No Amount: _____