South Coast Pediatric Dentistry

Dr. Kent N. Do
Pediatric Dentist

FIRST VISIT REGISTRATION & HEALTH HISTORY

Your Child

Child's Name _____ Date _____
Last First Mi

Nickname _____ Gender ❑ Male ❑ Female

Date of Birth _____ Age _____ Phone _____

School _____ Grade _____ SS# _____

Child's Address _____ City _____ State _____ Zip _____

Who is accompanying child today? _____ Relationship _____

Whom may we thank for referring you to our office? _____

Name and ages of other children in family: _____

Is he or she a foster child? ❑ Yes ❑ No How long has he or she been in your custody? _____

Responsible Party

Name _____ Relationship _____

Address _____ SS# _____ DL# _____

Email _____ Home Phone _____ Cell _____ Work _____

Who is Responsible for Making Appointments? _____

Parent or Guardian Information ❑ Mother ❑ Father ❑ Stepmother ❑ Stepfather ❑ Guardian

Name _____ Address _____

Email _____ Phone-Home _____ Cell _____ Work _____

Employer _____ Occupation _____ SS# _____ DL# _____

Marital Status ❑ Single ❑Married ❑ Separated ❑ Divorced ❑ Widowed

Parent or Guardian Information ❑ Mother ❑ Father ❑ Stepmother ❑ Stepfather ❑ Guardian

Name _____ Address _____

Email _____ Phone-Home _____ Cell _____ Work _____

Employer _____ Occupation _____ SS# _____ DL# _____

Marital Status ❑ Single ❑Married ❑ Separated ❑ Divorced ❑ Widowed

Emergency Contact Information

Name _____ Address _____

Relationship _____ Phone-Home _____ Cell _____ Work _____

Primary Insurance

Insured's Name _____ Relationship _____

Birthdate _____ SS# _____

Employer _____ Date Employed _____ Occupation _____

Insurance Co. _____ Group # _____ Employee # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Additional Insurance

Insured's Name _____ Relationship _____

Birthdate _____ SS# _____

Employer _____ Date Employed _____ Occupation _____

Insurance Co. _____ Group # _____ Employee # _____

Ins. Co. Address _____ City _____ State _____ Zip _____

Has your child ever had any of the following:

Yes	No		Yes	No		Yes	No	
❑	❑	Aids/HIV	❑	❑	Difficulty Swallowing	❑	❑	Pneumonia
❑	❑	AttentionDeficit/Hyperactivity	❑	❑	Drug or Alcohol Abuse	❑	❑	Pregnancy
❑	❑	Anemia	❑	❑	Epilepsy	❑	❑	Psychiatric Disorder
❑	❑	Allergy/Asthma	❑	❑	Endocrine/Growth	❑	❑	Rheumatic Fever
❑	❑	Autism	❑	❑	Disorders	❑	❑	Scarlet Fever
❑	❑	Bleeding Abnormalities	❑	❑	Eye Problems	❑	❑	Scoliosis
❑	❑	Brain Injury	❑	❑	Fainting/Dizziness	❑	❑	Sinus Problems/Snoring
❑	❑	Bronchitis	❑	❑	Frequent Vomiting	❑	❑	Sore Throat (frequent)
❑	❑	Bruises Easily	❑	❑	Hearing Loss	❑	❑	Enlarged Tonsils/ Adenoids
❑	❑	Cancer	❑	❑	Heart Disease/Murmur			
❑	❑	Cerebral Palsy	❑	❑	Hemophilia	❑	❑	Spina Bifida
❑	❑	Chicken Pox	❑	❑	Hepatitis	❑	❑	Syndrome
❑	❑	Cleft Lip/Palate	❑	❑	Jaundice	❑	❑	Tuberculosis
❑	❑	Communicable Disease	❑	❑	Leukemia	❑	❑	Other:
❑	❑	Convulsions/Seizures	❑	❑	Measles			
❑	❑	Developmental Delay	❑	❑	Mental Retardation			
❑	❑	Diabetes	❑	❑	Mumps			

Please explain any checked items:

_____

❑ This child has never been diagnosed as having any of the above conditions.

How often does your child brush?_____Floss?_____

Is brushing/flossing supervised? ❑ Yes ❑ No By whom? _____

Is the child's water fluoridated? ❑ Yes ❑ No ❑ Don't Know

Is your child receiving fluoride supplements? ❑ Yes ❑ No

❑ Tablets ❑ Drops Dose: _____

Is this your child's first dental visit? ❑ Yes ❑ No

Previous Dentist & City _____

Date of last visit _____ Date of last dental x-rays _____

Any injuries to your child's teeth or jaw? ❑ Yes ❑ No

When/What _____

Has your child had recent dental pain? ❑ Yes ❑ No

Explain _____

❑ Breast-feeding (till Age) ❑ Bottle (till Age)

❑ Thumb/Finger Sucking ❑ Pacifier ❑ Nail Biting

❑ Dental Grinding/Clenching ❑ Mouthbreathing/Snoring

Has your child experienced any unfavorable reaction from previous medical or dental care? ❑ Yes ❑ No Explain: _____

Child's Physician _____ Phone _____

Address _____

Date of Last Exam (list results) _____

Please list any serious medical problem, hospitalizations, surgeries the child has had _____

_____

Please list all medications the child is currently taking (Give reasons) _____

Premedication prior to dental treatment? ❑ Yes ❑ No Why? _____

Is your child under the care of a specialist for any medical reason? ❑ Yes ❑ No Why? _____

Specialists Name _____ Phone _____

Does your child have a physical or medical disability/delay? ❑ Yes ❑ No Please list _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? ❑ Yes ❑ No

(if yes, please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc)? ❑ Yes ❑ No

Is the child up to date on immunizations? ❑ Yes ❑ No

Do you wish to speak to the doctor privately about a special concern ❑ Yes ❑ No

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 also authorize Dr. Do and staff to perform necessary dental procedures including, but not limited to, the use of nitrous oxide, local anesthetic and take any necessary radiographs to diagnose and/or treat my child's dental needs. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I also authorize Dr. Do 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 other healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my 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 of my dependents.

Signature of Patient (or Parent/Guardian if minor)_____ Date_____

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HIPAA Acknowledgement of Receipt of the Notice

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize South Coast Pediatric Dentistry to use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to renew and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of notice.

I understand that I have the right to request restriction on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this_____day of_____, 20_____.

_____ _____

Print Patient Name Relationship To Patient

_____

Signature