San Jose Dental Specialists

Children Dentistry & Orthodontics

PATIENT INFORMATION FORM

Date:_____ Social Security Number: _____-_____-_____

Patient's Name: _____ Gender: M F Birth Date: _____ Age:_____

LAST NAME FIRST NAME MI

Home Address: _____ Apt: _____ City:_____ State: _____ Zip: _____

Home Phone #: _____ Cell:_____ Email: _____

Whom may we thank for referring you? _____ Phone #: _____

Emergency Contact Name: _____ Phone #: _____

If patient is a minor, please provide the following information:

Father's Name: _____ Mother's Name_____

Date of Birth: _____ Age: _____ Date of Birth: _____ Age: _____

Address (if different): _____ Address (if different): _____

_____ _____

Phone #: _____ Cell:_____ Phone #: _____ Cell:_____

Email: _____ Email: _____

Primary Insurance

Person responsible for account:

_____

Relation to Patient: _____

Birthdate: _____

Soc. Sec. #: _____

Employer: _____

Work #: _____

Occupation: _____

Insurance Company:

_____

Policy #: _____

Group #: _____

Phone #: _____

Name of other dependants covered under this plan:

_____

_____

Additional Insurance

Person responsible for account:

_____

Relation to Patient: _____

Birthdate: _____

Soc. Sec. #: _____

Employer: _____

Work #: _____

Occupation: _____

Insurance Company:

_____

Policy #: _____

Group #: _____

Phone #: _____

Name of other dependants covered under this plan:

_____

_____

For Office Use

Orthodontic: __ Pedo: ____

Coverage %: _____

Eff. Date: _____

Eligibility:

_____

_____

If not eligible, are Xrays and diagnostic procedures covered? Yes____ No___

Maximum Orthodontic Benefit:_____

Have orthodontic benefit been reduced by previous treatment? Yes___ No___

Amount used:_____

Amount remained: _____

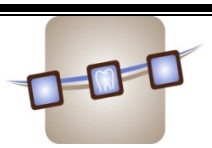
Authorization

- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize my insurance company to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.
- I authorize the dentist to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for all charges whether or not paid by insurance.

Parent/Guardian Signature: _____ Date: _____

Payment is due in full at time of treatment unless prior arrangements have been approved.

Patient's Name: _____
LAST NAME FIRST NAME MI



Medical History

Physician's Name: _____ Phone #: _____

Is the patient allergic to latex? ☐Yes ☐No Please list: _____

Any allergies to medication? ☐Yes ☐No Please list: _____

Any other allergies? ☐Yes ☐No Please list: _____

Has the patient ever been hospitalized? ☐Yes ☐No Please describe: _____

Is the patient currently taking any medications? ☐Yes ☐No Please list: (including Bisphosphonate)_____

Does the patient have any heart condition? ☐Yes ☐No Please explain: _____

Young women: Is the patient taking birth control? ☐Yes ☐No Is the patient pregnant? ☐Yes ☐No

Check if the patient has/had any of the following:

☐ AIDS/HIV+	☐ ADD/ADHD	☐ Asthma	☐Autism
☐ Bleeding Problems	☐ Blood Disease	☐ Blood Transfusion	☐ Cancer
☐ Cerebral Palsy	☐ Chemotherapy	☐ Chronic Respiratory Infections	☐ Cleft Lip/Palate
☐ Craniofacial Problems	☐ Convulsions (seizures)	☐ Cortisone Treatments	☐ Diabetes
☐ Dizziness	☐ Downs Syndrome	☐ Ear Aches	☐ Emotional Problems
☐ Epilepsy	☐ G-Tube	☐ Handicap/Disabilities	☐ Head Injuries
☐ Hearing Impaired	☐ Heart Defect	☐ Heart Disease	☐ Heart Murmur
☐ Hemophilia	☐ Hepatitis	☐ Hydrocephalus	☐ Kidney Problems
☐ Leukemia	☐ Lung Disease	☐ Mental Disorders	☐ Pheumonia
☐ Premature Birth	☐ Radiation Therapy	☐ Rheumatic fever	☐ Shortness of Breath
☐ Sickle Cell Trait/Disease	☐ Speech Problems	☐ Tumors	☐ Thyroid Conditions
☐ Tuberculosis	☐ NOT up to date on immunizations		

☐ Any other disorder: Please describe: _____

Dental History

Reason for today's visit: _____ Former Dentist: _____Phone #:_____

Date of last dental care: _____ Date of last dental x-rays: _____

If patient is a minor, has the patient seen a pediatric dentist before? ☐Yes ☐No

Is the patient's water fluoridated? ☐Yes ☐No Is the patient taking any fluoride supplements? ☐Yes ☐No

Does the patient brush daily? ☐Yes ☐No How often? ____ Does the patient floss daily? ☐Yes ☐No How often? _____

Has the patient had any complications following dental treatment? Please explain: _____

Any clicking or pain when opening or closing the jaw? ☐Yes ☐No Please Describe: _____

Has the patient ever injured teeth or jaw in a fall or other type of accident? ☐Yes ☐No Please Describe: _____

Did the mother or father of the patient have any teeth removed because of crowding? ☐Yes ☐No

Does anyone in the family have the same condition?_____Relationship_____

Please check yes or no if you have ever had any of the following habits:

☐ Thumb sucking	☐ Mouth breathing	☐ Ginding of teeth	☐ Nail biting
☐ Tongue biting	☐ Tongue thrusting	☐ Lip biting	☐ Cancer

Patient/Parent/Guardian Signature: _____ Date: _____