



Pediatric Dental/Medical History Form

Dental Wellness Center
5406 E. Village Road
Long Beach, CA, 90808

(562) 421-3747
www.LongBeachHolisticDentist.com
leanne@rpmdentistry.com

Tell Us About Your Child

Child's Name: _____ Nickname: _____
Last Name First Name MI

Gender: Male Female Birth Date: _____ Age: _____

School: _____ Grade: _____

Child's Home #: _____ SS#: _____

Child's Home Address: _____

City: _____ State: _____ Zip Code: _____

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of this child? Yes No Whom may we thank for referring you? _____

Other family members seen by us: _____

Previous / Present Dentist: _____ Last Visit Date: _____

Marital Status: Married Single Widowed Divorced Separated

Mother of Child

Name: _____

Birthdate: _____ Cell Ph: _____

Hm Ph: _____ Wk Ph: _____

Employer: _____

Email: _____

SS#: _____ DL#: _____

Father of Child

Name: _____

Birthdate: _____ Cell Ph: _____

Hm Ph: _____ Wk Ph: _____

Employer: _____

Email: _____

SS#: _____ DL#: _____

Person responsible for account

Billing:

Name: _____ Relation: _____
Last Name First Name MI

Billing Address: _____

City: _____ State: _____ Zip Code: _____

Home Ph. _____ Employer: _____ Work #: _____

Appointments:

Name: _____ Hm # _____ Wk #: _____
Last Name First Name MI

Primary Dental Insurance

Insurance Co. Name: _____

Group # (Plan,Local, or Policy #): _____

Address: _____

Phone #: _____

Policy Owner Name: _____

Relationship to Patient: _____

Birthdate: _____ SS#: _____

Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Group # (Plan,Local, or Policy #): _____

Address: _____

Phone #: _____

Policy Owner Name: _____

Relationship to Patient: _____

Birthdate: _____ SS#: _____

Employer: _____

What is the primary reason for the child's appointment?

Reason for first visit:

Child's Interests, Hobbies: _____

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

Is the child's water fluoridated? Yes No

Is the child taking fluoridated supplements? Yes No

Has the child ever had any pain/tenderness in his/her jawjoint (TMJ/TMD)? Yes No

Does the child have headaches, neck pain or balance problems? Yes No

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

Does the child floss (or someone) his/her teeth daily? Yes No

Child's Physician: _____ Phone: _____ Last Visit: _____

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health: Good Fair Poor

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

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

Has the child ever had any of the following medical problems?

	Yes	No		Yes	No		Yes	No
Abnormal Bleeding	<input type="radio"/>	<input type="radio"/>	Congenital Heart Defect	<input type="radio"/>	<input type="radio"/>	Hemophilia	<input type="radio"/>	<input type="radio"/>
Drug Allergies	<input type="radio"/>	<input type="radio"/>	Convulsions/Epilepsy	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>
Any Hospital Stays	<input type="radio"/>	<input type="radio"/>	Diabetes	<input type="radio"/>	<input type="radio"/>	HIV+/AIDS	<input type="radio"/>	<input type="radio"/>
Any Operations	<input type="radio"/>	<input type="radio"/>	Handicaps/Disabilities	<input type="radio"/>	<input type="radio"/>	Kidney/Liver	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	Hearing Impairment	<input type="radio"/>	<input type="radio"/>	Rheumatic/Scarlet Fever	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	Heart Murmur	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>

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

Does the child have any of the following habits?

Lip Sucking/Biting Yes No

Nail Biting Yes No

Nursing Bottle Habits Yes No

Thumb/Finger Sucking Yes No

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. **I authorize the dental staff to perform the necessary dental services my child may need.**

Signature of Parent or Guardian: _____

Date: _____

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

Client: _____ Date: _____

Dental treatment is an excellent investment in an individual's physical and psychological well being. Financial considerations should not be an obstacle to obtaining this important health service. Being sensitive to the fact that different people have different needs in fulfilling their financial obligations, we are providing the following payment options.

PAYMENT OPTIONS:

Two Payments (for treatment over \$1,000 that have more than one visit)

Total patient obligation may be divided as follows: 50% due at the first treatment visit, with the remaining balance paid at last visit. For any fees under \$1,000, the full amount is due at the initiation of any procedure.

Treatments today ... Payments tomorrow ...

We are pleased to offer Care Credit. It is convenient, no initial payment, low monthly payment plan for dental treatments of \$200 to \$25,000. Offering Care Credit allows us to make the smile you've always wanted affordable.

Apply from home:

Care Credit: 1-800-365-8295

Apply online 24 hours, 7 days a week:

Care Credit: www.carecredit.com

Pay as You Go. You may choose to pay your entire obligation for each visit, at the visit.

FORMS of PAYMENT and BALANCES DUE

In order to facilitate access to the very best health care possible, you may choose from any of the following (including any combination thereof): **Cash, Visa, MasterCard, American Express, Discover, Money Order, Personal Checks or Care Credit (see above).**

I have read and understand all the above _____
Patient Signature