

ALAMEDA PEDIATRIC DENTISTRY (510) 521-5016
PLEASANTON PEDIATRIC DENTISTRY (925) 846-5437

Parent/Guardian Responsible for Account _____
Address _____ City _____ Zip _____
Home # _____ Work # _____ Emg/Cel# _____
Social Security # _____ Birth Date _____ Driver's License # _____
Employer _____ Occupation _____
Employer's Address _____ City _____ Zip _____

Dental Insurance with this Employer? Yes No
Insurance Company _____ Group Name _____
Group or Policy # _____ Local # _____

Spouse's Name _____
Address (if different from above) _____ City _____ Zip _____
Home Phone _____ Work Phone _____ Emg/Cel# _____
Social Security # _____ Birth Date _____ Driver's License # _____
Employer _____ Occupation _____
Employer's Address _____ City _____ Zip _____

Dental Insurance with this Employer? Yes No
Insurance Company _____ Group Name _____
Group or Policy # _____ Local # _____

Do parents and child all live together? Yes No If no, explain, _____

CHILD'S HISTORY

Name _____ Nick Name _____
Male Female Birth Date _____ Age _____
School Name _____ Weight _____
Name of former Dentist _____ City _____ Last Visit _____

Has any member of your family been a patient of this office before? Yes No
Name(s) _____

Current dental problems _____

Is your child:
In good health _____ Yes No
Sensitive or allergic to any drug(s) or latex products _____ Yes No
Taking any drug(s) or medicine _____ Yes No
Taking fluoride daily other than water _____ Yes No

Has your child had (please circle): hearing difficulty, speech impediment, seizures, mental disturbance, cerebral condition, liver disease, kidney disease or HIV?

Has your child had any history of (please circle): asthma, rheumatic fever, heart trouble, heart murmur, diabetes, tuberculosis, profuse bleeding or emotional problems?

Does your child have any other special problem? _____ Yes No

If yes, please explain _____

Name of child's physician _____
Physician address _____ City _____ Zip _____
Physician Phone _____ Patient's Medical record # _____

Would you like us to inform your child's physician of our dental findings? Yes No
Who may we thank for referring you to our office? _____

I authorize routine dental diagnostic procedures for my child. If I accept the proposed treatment plan, I also agree to the use of anesthetics and pre-medications considered necessary or advisable by the dentist for the comfort and well being of the child. All past due balances are subject to a finance charge of 1 1/2 % per month, which is an annual rate of 18% and/or are subject to all legal and collection expenses.

Parent/Guardian _____ Date _____