Patient Name: ____ DOB:_____________
Last Name First Name MI

Other Child's Name: ____ DOB:_____________

Other Child's Name: ____ DOB:_____________

Responsible Party 1:

Responsible for Account: ____________________________________ Relation:_____________

DOB:______________________ Social Security Number: _______________________________

Address: ____

City: ____ State:________ Zip Code: ___________

Cell #: ____________________Email address: ______________________________________

Primary Insurance:

Subscriber Name: ____ DOB: ____________

Relation to Patient: ________________________________ SSN: __________________________

Employer: ____________________________ Insurance Company: _______________________

Insurance Address: ____

City: ____ State:________ Zip Code: ___________

Subscriber Number: ____________________________ Group #: __________________________

Additional Insurance:

Subscriber Name: ____ DOB: ____________

Relation to Patient: ________________________________ SSN: __________________________

Employer: _____________________________ Insurance Company: ______________________

Insurance Address: ____

City: ____ State:________ Zip Code: ___________

Subscriber Number: ____________________________ Group #: __________________________

Would you like to receive text messages to communicate with our office?

___Yes ____No

Signature: ____ ***Date:*** ______________________

Print Name: ____

CONFIDENTIAL MEDICAL HISTORY

Child's physician:____ **Phone** #____________________

Is your child in good general health? Yes/No

If no please describe:____

Where there any problems at birth? Yes/No

If yes please describe:____

Are your child's immunization shots all up to date? Yes/No **Any drug or food allergies?** Yes/No

If so please list____

Has your child had any surgical operations? Yes/No

If so, please describe:____

Has your child ever been hospitalized? Yes/No

If yes, please explain:____

Please circle yes or no for any of the following conditions you child has had or now has

Allergies	Y / N	Intellectual Disability	Y / N	High fever	Y / N
Autism Specturm	Y / N	Convulsions/seizures	Y / N	Cancer/tumor/cysts	Y / N
PDD-NOS	Y / N	Rheumatic fever	Y / N	Diabetes	Y / N
Eating Disorder	Y / N	Kidney disease	Y / N	High/low Blood pressure	Y / N
Steroid therapy	Y / N	Frequent diarrhea	Y / N	Sinus problems/drainage	Y / N
Asthma	Y / N	Blood disease	Y / N	Ear/eye/nose/throat problem	Y / N
Abnormal bleeding	Y / N	Cleft lip or palate	Y / N	Liver disease	Y / N
Chemotherapy	Y / N	Mumps or measles	Y / N	Tuberculosis	Y / N
Heart trouble	Y / N	Anemia	Y / N	Stomach ulcer	Y / N
Blood transfusion	Y / N	Scarlet fever	Y / N	Jaundice/hepatitis	Y / N
Mental disorder	Y / N	Chicken pox	Y / N	Problems with anesthesia	Y / N
Heart Murmur	Y / N	AIDS virus	Y / N	Thyroid disease	Y / N
Birth defects	Y / N	Down Syndrome	Y / N		

*Any other condition?*____

CURRENT MEDICATIONS:____
____
____

I hereby affirm that this history is correct to the best of my knowledge:

PATIENT NAME:____

SIGNATURE OF PARENT OR GUARDIAN:___________________________________

WITNESS:__________________________ DATE:________________

CONFIDENTIAL SOCIAL HISTORY:

Circle if your child has any problems with the following? Speech / hearing / vision / sleep

Do you consider your child to be? Advanced learner / progressing normally / slow learner

Your child's first language?____________________________________

Second language?__________________________

Is your child adopted? Yes / No. If so at what age?___________

How does your child tolerate medical or dental treatment?__________________________________

Your child's favorite things? (Pet, toy, color, friend, hobby etc.)_____________________________

CONFIDENIAL DENTAL HISTORY:

Why is your child here today?____

Is this your child's first dental visit? Yes/No. If no, when was the last visit?______________________

Does your child receive fluoride in any form? Yes/No. If so, in what form?_____________________

Have there been any injuries to your child's teeth?_______________________________________

How often does your child brush?____________ Floss?_________ At what age did your child stop using a bottle?__________ Sippy Cup?_____________

OFFICE POLICIES

It is the policy of this office to inform parents/guardians of all procedures planned for your child. Each regular examination appointment consists of oral hygiene instruction, cleaning of the teeth, topical fluoride application, x-rays if needed, and examination of the teeth, hard/soft tissues of the mouth, and the bite. *Any other treatment needed such as sealants, fillings, caps, extractions, etc, will be performed at a separate visit after obtaining your permission.*

APPOINTMENT POLICY

MISSED APPOINTMENT POLICY: We require 24 hour notice for cancellation of any appointments. Although we do understand emergencies and other circumstances arise, if any appointment is missed without 24 hours notice a $50 cancellation fee/child will be charged to the account. After more than 2 missed appointments without proper cancellation, the doctor-patient relationship will be terminated.

FINANCIAL POLICY

INSURANCE BENEFITS: It is the sole responsibility of the insurance policy holder to understand their coverage and benefits, including deductible, plan maximum, and coverage details. As a courtesy, this office will assist in the filing of insurance claims and preparation of estimates for each appointment, **however, it is very important to understand that insurance plans do not cover all services and do not always disclose this information to the provider.** Payment is expected at time of service. Any overpayment that is received from an insurance company will be credited or refunded, and any balance remaining will be billed to the responsible party. It is also your responsibility to inform this office of any changes in dental insurance coverage and also update any changes in address or contact phone numbers. Treatment estimates are only estimates, and this office cannot be held responsible for 100% accuracy of estimates. Any account that is 90 days past due is subject to being sent to collections, and the responsible party will be held responsible for any collection and/or attorney fees.

I hereby verify that I that I have read and understood the policies stated above, and give permission for Valley Pediatric Dentistry and their affiliates to contact me in matters related to this form:

PATIENT(S) NAME:____

SIGNATURE OF PARENT OR GUARDIAN:_____________________________________

WITNESS:____

DATE:_________________

Date:_________________________

In my absence, I hereby give authorization for the person(s) listed below to bring my child(ren) to Valley Pediatric Dentistry and to consent for any and all recommended dental/medical services.

Legal guardian must bring child to first dental appointment.

Child(ren) names and date of birth:	Authorized person(s)/Relationship to child(ren)
______________________________	____
______________________________	____
______________________________	____
______________________________	____

Parent/Legal Guardian signature:____
Printed name:____
This authorization will remain in effect until changes are made by the parent/guardian as signed above.

****
Minor Children (ages 15, 16, and 17 only)
My child(ren), ______________________________________may be seen for dental attention in the office of Valley Pediatric Dentistry WITHOUT a parent or legal guardian present.
Parent/Legal Guardian:____

****
Adults (ages 18 years or older-ONLY)
I give my consent for the listed person(s) below to have any and all access to my dental records on file with Valley Pediatirc Dentistry.
Adult Signature:____
Information may be shared with:____