CHILDRENS DENTISTRY

Zinnia Carlos Regala, DDS

&

Associates

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We.come to our office!! The following is for our records only, and will be considered confidential. Please complete **BOTH** sides of this form by printing the information…it will help us give your child the best possible dental care. Thank You.

Today's date: _____

CHILD'S legal name_____ Nickname _____ Sex: ☐ M ☐ F

CHILD'S Social Security # _____ Age _____ Date of Birth _____

School Name/ City _____ Tel ( ) _____ Grade _____

Reason for visit _____ Who is accompanying child? _____ Referred to our office by_____

Has any member of your family been to this office before? If yes, name _____

FAMILY RECORD

Home Address _____ City _____ Zip _____ Phone ( ) _____ _____

Family Email Address _____ Father's Cell #_____Mother's Cell #_____

FATHER'S full name _____ Birthdate _____ **Social Security #** _____

☐ Mr. ☐ Dr. Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widower ☐ Other

Address (if different) _____ Home Tel ( ) _____

Occupation _____ How long? _____ Employed by _____

Business address _____ City/State _____ Zip _____ Tel ( ) _____

MOTHER'S full name _____ Birthdate _____ **Social Security #** _____

☐ Mrs. ☐ Ms. ☐ Dr. Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widow ☐ Other

Address (if different) _____ Home Tel ( ) _____

Occupation _____ How long? _____ Employed by _____

Business address _____ City/State _____ Zip _____ Tel ( ) _____

DENTAL HISTORY

Is this your child's first dental visit? ☐ YES ☐ NO

Previous dentist's name _____ City/State _____ Date of last visit _____

Has your child had an unfavorable experience in a previous dental or medical office? ☐ YES ☐ NO

If yes, what _____

Have there been any injuries to your child's teeth or jaws – falls, chips, etc.? ☐ YES ☐ NO

If yes, explain _____

Does your child, or any members of the family, have a history of missing or extra teeth? ☐ YES ☐ NO

If your child receives fluoride vitamins, tablets, water, etc. please **CIRCLE** which one.

Has your child had a toothache recently? ☐ YES ☐ NO

If yes, specify area _____

Does your child have any thumb or lip sucking, lip or nail biting, nursing bottle or pacifier habits? ☐ YES ☐ NO

If yes, **CIRCLE** the habit from the list above, or write any other habit here _____

MEDICAL HISTORY

Name of child's physician _____ Address _____ Tel ( ) _____

Is your child allergic, or had any unfavorable reaction to any food, medicine, local anesthetic, penicillin, latex, etc.? ☐ YES ☐ NO

Is your child presently under the care of a physician for any medical problem, condition or pending surgery? ☐ YES ☐ NO
If yes, what _____

Is your child currently taking any medications? ☐ YES ☐ NO
What _____ Why _____

Please **CHECK** any of the following conditions if your child has had any symptoms or been diagnosed for:

☐ Heart trouble ☐ Murmurs ☐ Rheumatic fever ☐ Diabetes ☐ Asthma ☐ Epilepsy ☐ Kidney
☐ Liver problems ☐ Hepatitis ☐ Bleeding disorders ☐ Blood transfusions ☐ Cerebral palsy ☐ Tuberculosis ☐ Convulsions
☐ Premature birth ☐ Attention Deficit Disorder (ADD) ☐ Brain injury ☐ Seizures ☐ Autism

Has your child had any diagnosis of immunological problems, or tested positive for H.I.V.? If so, **CIRCLE** condition. ☐ YES ☐ NO

Has your child ever been hospitalized or had surgery? ☐ YES ☐ NO
What _____ When _____

Does your child have any special needs, handicaps or disabilities we should be aware of? ☐ YES ☐ NO
What _____

Because conditions in the mouth can be hereditary, it is important to know if your child is adopted. ☐ YES ☐ NO
If yes, does he/she know? ☐ YES ☐ NO

Is there any other medical history or problem you feel should be brought to the doctor's attention? ☐ YES ☐ NO
What _____

Please state name, address and telephone # of person (outside immediately family) to be contacted in event of any emergency.
Name _____ Address _____
City _____ State _____ Zip _____ Tel ( ) _____

Health History Reviewed by:

Dr : _____	Dr : _____	Dr : _____
Date : _____	Date: _____	Date : _____
Comments: _____	Comments: _____	Comments: _____
_____	_____	_____

FINANCIAL RESPONSIBILITY

Is your child eligible for dental insurance benefits? If yes, please supply the following information.

Primary Insurance:
Insurance Co. _____ Tel # ( ) _____
Insurance Address _____
Insured Name _____ Relationship _____
Insured ID/Employee # _____ Group # _____
Employer _____

Secondary Insurance:
Insurance Co. _____ Tel #( ) _____
Insurance Address _____
Insured Name _____ Relationship _____
Insured ID/Employee # _____ Group # _____
Employer _____

If family is **NOT** living together, person who brings patient to the appointment is financially responsible for the child's account regardless of insurance.

⊗ AS A NEW PATIENT, A FINANCIAL HISTORY HAS NOT BEEN ESTABLISHED WITH THIS PRACTICE. THEREFORE, I AGREE TO PAY FOR TODAY'S CHARGES IN FULL AS FOLLOWS:

☐ Cash or check ☐ MasterCard / Visa / Discover / American Express

AUTHORIZATION

I hereby authorize Dr. Carlos Regala and Associates to obtain further information on any health questions, and I understand that it is my responsibility to keep this practice informed of any changes to the medical history or condition of the patient. I hereby give my permission for this practice to use x-rays, photographs, cleaning and fluoride, when necessary, to properly diagnose and record any and all dental conditions. I understand that treatment will not be rendered without my consent. If a parent or legal guardian is not with the patient for this appointment, my signature below indicates that I have completed this form, and that the individual named on side one of this form is authorized to accompany the child to Dr. Carlos Regala's office.

Signature of Parent or Legal Guardian _____ **Date** _____