Children's Dentistry of Redlands
Welcome to our practice!

We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your child oral habits which will help keep their smile beautiful for their lifetime.

Your Child

Child's Name_____
Nickname_____Sex___
Birthdate_____
Address_____
City_____State_____
Zip Code_____Phone_____
Child lives with_____

Mother ☐ Stepmother ☐ Guardian

Name_____
Home Phone_____
Work Phone_____
SSN_____D.O.B_____
Employer_____

Father ☐Stepfather ☐Guardian

Name_____
Home Phone_____
Work Phone_____
SSN_____D.O.B._____

Employer_____

Parent/Guardian Marital Status

☐Single ☐Married ☐Separated
☐Divorced ☐Widowed

Primary Dental Insurance

Insured's Name_____
Relationship_____
D.O.B._____
SSN/ID_____
Employer_____
Insurance Co._____
Phone _____
GroupNo._____
Address_____

Secondary Insurance

Insured's Name_____
Relationship_____
D.O.B._____SSN_____
Employer_____
Insurance Co._____
Phone_____
Group No._____
Address_____

Who makes childs appointments

(Responsible Party)

Name_____
Home Phone_____
Cell Phone_____
Work Phone_____
Best time to call_____
Email Address_____
_____

Who may we thank for your referral?_____

Signature_____**Date**_____

Health History

Your child's overall health as well as any medications your child takes could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Childs Name_____
Date of Birth_____
Today's Date_____

Dental History

How often does your child brush? _____
How often does your child floss? _____
Is this your child's first visit to the dentist? _____
Date of last dental visit_____
Previous dentist_____
Has your child had any difficulty with previous visits? ▫ Yes ▫No
Comments_____
Childs Physician_____
Address _____
Phone Number_____

Does your child have any of the following habits?

Suck thumb/finger	▫Yes ▫No
Suck/bite lip	▫Yes ▫No
Bite/chew nails	▫Yes ▫No
Pacifier	▫ Yes ▫No
Chew hard objects	▫ Yes ▫No
Grind teeth	▫ Yes ▫No
Clench jaw	▫ Yes ▫No
Is your child's water fluoridated?	▫Yes ▫No ▫Don't know
Does your child take fluoride supplements?	▫Yes ▫No ▫Don't know

Please complete other side

Medical History

Has your child ever had any of the following?

ADD/ADHD	□yes	□no	Down Syndrome	□yes	□no
Abnormal Bleeding	□yes	□no	Handicaps/Disabilities	□yes	□no
Allergies/Hay fever	□yes	□no	Heart Murmur	□yes	□no
Asthma	□yes	□no	Type_____		
Autism	□yes	□no	Hemophilia/Bleeding Disorder	□yes	□no
Cancer/Hepatitis	□yes	□no	HIV/AIDS	□yes	□no
Cerebral Palsy	□yes	□no	Rheumatic Fever	□yes	□no
Congenital Heart Defect	□yes	□no	Sickle Cell Anemia or Trait	□yes	□no
Convulsions/Epilepsy	□yes	□no	Tuberculosis	□yes	□no
Diabetes	□yes	□no			

Has your child ever taken Fen-Phen/Redux? □yes □no

Persistent cough or throat clearing not associated with known illness? □yes □no
(Lasting more than three weeks)

Is your child taking any medications? □yes □no

Please List_____

Is your child allergic to any foods or medications? □yes □no

Please List_____

Is your child allergic to Latex? □yes □no

Is your child allergic to local anesthetic (Novocain)? □yes □no

Please explain any medical problems your child may have_____

_____

Is there any other information we should be aware of?_____

_____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or other dental practioners. I authorize and request my insurance company to pay directly to the dentist or dental group insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for the payment of all services rendered on my behalf or my dependents including late charges and finance charges. I agree to pay any attorney fees, collection fees or court costs to satisfy this obligation. I understand there is a twenty-five dollar broken appointment fee per half hour my child is scheduled without twenty-four hour notice. Chronic failed appointments may be subject to dismissal from this office.

Signature_____**Date**_____

Reviewed with parent_____**Date**_____

Children's Dentistry of Redlands
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(909)793-7274

OUR FINANCIAL POLICY

Non-insured patients are expected to pay in full with cash, check or credit card the day service is rendered.

For those patients who are covered by insurance, we will accept assignment of benefits. This means you must sign the portion of your insurance that "assigns" payment to our office. Most dental insurance plans do not cover 100% of the cost of your treatment. Because of this and the extreme delay in receiving payment from the insurance company, you will be asked to pay your deductible and your portion of charges the day services are rendered. All estimates are based on information provided to us by your insurance and are not a guarantee of payment. Only after a claim is submitted and reviewed by your insurance company can final payment be determined. We are a non-preferred provider for most PPO insurance plans and this may also affect your out of pocket cost. If you are unsure if we are a provider, please feel free to ask the receptionist.

We will estimate as closely as possible your coverage, but until we actually receive payment from your insurance company, IT IS JUST AN ESTIMATE. We will assist you in dealing with your insurance company, but the ultimate responsibility lies with you. After forty-five days, any remaining balance not received from your insurance company will be due in full from you. All unpaid balances over thirty days are subject to a finance charge of 18.00% as well as a five-dollar late charge.

Feel free to ask any questions that remain unanswered either before or after treatment. We wish to help you all we can.

Sincerely,

Children's Dentistry Of Redlands

I have read the above and understand it_____ Date_____
(Parent or Guardian signature)