



Raul Perez, DDS

Orthodontics and Dentistry for Kids

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.

We confirm all appointments via email. If you do not have email, we will confirm by phone.

Email _____

Mother
 Stepmother **Guardian**

First _____ M.I. _____
Last _____
Home Phone _____
Work Phone _____
Cell Phone _____
SS# _____
Date of Birth _____
Employer _____
Occupation _____
DL# _____

Your Child

Child's First _____
M.I. _____ Last _____
Preferred _____ Sex _____
Date of Birth _____ Age _____
SS# _____
Child's Home Address _____

City _____
State/Prov. _____
ZIP _____
Phone _____

Father

Stepfather **Guardian**

First _____ M.I. _____
Last _____
Home Phone _____
Work Phone _____
Cell Phone _____
SS# _____
Date of Birth _____
Employer _____
Occupation _____
DL# _____

Dental Insurance

Insured's name _____ Relationship _____
Date of Birth _____ SS# _____ Employer _____
Ins. Company _____ Group # _____ ID# _____

Nearest Relative

First _____ M.I. _____
Last _____
Relationship _____
Address _____

Home Phone _____
Work Phone _____ Ext. _____
Cell Phone _____

Parent's Marital Status

Single Divorced
 Married Widowed
 Separated

How did you hear about us?

Medical History

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

Has your child ever had any of the following:

- | | |
|--|--|
| Asthma <input type="checkbox"/> Yes <input type="checkbox"/> No | Rheumatic Fever <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Cancer <input type="checkbox"/> Yes <input type="checkbox"/> No | Congenital Heart Defect <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hepatitis <input type="checkbox"/> Yes <input type="checkbox"/> No | Handicaps/Disabilities <input type="checkbox"/> Yes <input type="checkbox"/> No |
| HIV/AIDS <input type="checkbox"/> Yes <input type="checkbox"/> No | Convulsions/Epilepsy <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Hemophilia <input type="checkbox"/> Yes <input type="checkbox"/> No | Abnormal Bleeding <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Diabetes <input type="checkbox"/> Yes <input type="checkbox"/> No | Heart Murmur <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Allergies <input type="checkbox"/> Yes <input type="checkbox"/> No | ADHD/ADD <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Autism <input type="checkbox"/> Yes <input type="checkbox"/> No | Kidney Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Respiratory Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | Any Blood Disease <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Stomach or Intestinal Disease <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Previous Surgeries Yes No (if yes, what and when?)

Please explain any medical problems that your child has

Please list any medications your child may be taking

Please list anything your child may be allergic to

Dental History

How often does your child brush? _____

How often does your child floss? _____

Date of last dental visit _____

Previous Dentist _____

Child's Physician _____

Physician's Number _____

Has your child had difficulty with previous visits? _____

Is your child's water fluoridated? Yes No

Does your child take fluoride supplements? Yes No

Does your child:

Suck Thumb/finger Yes No

Suck/bite lips Yes No

Bite/Chew Nails Yes No

Chew Hard Objects (pencils, etc.)..... Yes No

Grind teeth Yes No

Clench Jaws Yes No

Office use

Medical Alert: _____

Hx: _____

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 the records of any treatment or examination rendered to my child to third party payors and/or other health practitioners. 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 payment of all services rendered on my behalf or my dependants.

X _____
Signature of parent or legal guardian, if minor

Date

