Children's Dental FunZone!
Children's Dental FunZone

Welcome

Please take a few minutes to fill out the questionnaire so we can best serve your needs. Thank you very much for your attention.

Child's Name_____ Nickname _____
Last First Middle Initial
Date of Birth _____ Age_____ Sex_____ Social Security Number _____
Address _____Apt#_____ City _____State _____ Zip_____
Parent/Legal Guardian's Name _____
☐ **I am not the legal guardian, but I have permission from the legal guardian to authorize children's dental FunZone to perform any dental care as needed.**
Home Phone ( ) _____ Parent's Work Phone ( ) _____
Parent's Cell phone ( ) _____ **E-mail**_____

❑ I consent to the dental practice using my cell phone number to (choose one or both) ❑ call or ❑ text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone number is (include area code) _____ _____ (initial)

Primary Insurance (Leave blank only if no dental benefits)
Subscriber_____ Relationship_____
Date of birth _____SS Number _____
Address (if different)_____
City_____ State_____ Zip_____
Phone ( )_____ Cell Phone ( )_____
Insurance Company_____
Employer _____ _____
Address _____Phone_____
City _____ State_____ Zip_____
Group# _____ Subscriber#_____

Secondary Insurance
Insurance Company _____
Subscriber_____ Relationship_____
Date of birth _____SS Number _____

Responsible Party Information
Father Name _____ D.O.B._____
Mother Name _____D.O.B._____
Address (if different)_____
City_____ State_____ Zip____
Phone ( )_____
Cell Phone ( )_____
Work ( )_____

Legal Guardian_____ D.O.B._____
Address (if different)_____
City_____ State_____ Zip____
Phone ( )_____
Cell Phone ( )_____
Work ( )_____

In case of emergency, contact _____ Phone ( ) _____

How did you hear about our office? _____

Informed Consent

I hereby authorize the dentists and staff at Children's Dental Fun Zone to perform diagnostic aids including x-rays, models and photographs as appropriate to make a thorough diagnosis of my child's dental needs.

I authorize my insurance company to pay the dentist(s) all insurance benefits otherwise payable to me for services rendered.

I authorize the use of this signature on all insurance submissions. I authorize the dentist(s) to release all information necessary to secure the payment of benefits.

I understand that I am financially responsible for all charges whether or not paid by my insurance.
I understand that I will be charged 18% APR for any past due balances over 60 days.

_____ _____ _____ _____
Signature **Date** **Dentist Signature** **Date**

Payment is due in full at time of treatment unless prior arrangements have been approved.

We provide our patients the option to participate in our online patient communication system. Some of the features include the ability to:

- Request appointments online
- Confirm appointments via Email
- Receive text Message Appointment Reminders
- Submit patient satisfactions surveys
- Refer your friends online

You may opt-out of your communications at any time by clicking the unsubscribe link found in the footer of each email or by replying to a text message with 'stop'. Standard Text Messaging rates apply.

We use this information to provide you with excellent treatment. We may disclose patient health information (PHI) to third parties that perform services for Children's Dental Fun Zone, in the administration of your benefits in accordance with HIPPA. These parties are required by law to sign a contract agreeing to protect the confidentiality of your PHI. Your PHI may be disclosed to an affiliate that performs services for Children's Dental Fun zone of West Covina in the administration of your benefits. Our affiliates do not send any

E-mail or other communications without user permission, and do not send spam. Please sign below that you agree to allow us to use this information in providing your services.

Dental History

Reason for Today's Visit _____

Is this your child's first visit to the dentist? Yes / No

If not, Former Dentist _____ Address _____Phone _____

Date of Last Dental Care _____ Date of Last X-rays _____ Reason for leaving _____

Does your child have any of the following?

Sensitivity to heat	Yes / No	Sores or growths in the mouth	Yes / No	Grinding teeth	Yes / No
Sensitivity to cold	Yes / No	Bad Breath	Yes / No	Bleeding gums	Yes / No
Sensitivity to biting	Yes / No	Loose teeth/Broken fillings	Yes / No	TMJ Disorder	Yes / No
Sensitivity to sweet	Yes / No	Swelling in the face	Yes / No	Clicking jaws	Yes / No

How often does your child brush? _____ how often does your child floss? _____

Is your child nervous towards previous dental treatment? If yes, describe _____

Do you have any particular concerns regarding your child's dental care? _____

Has your child or any member in your family had orthodontic treatment (braces)? Yes / No

Medical History

Physician's Name _____ Date of Last Visit _____

Was your child a patient in a hospital? Yes / No

If so, describe _____

Is your child now under medical care? Yes / No

Is your child taking any medications now? Yes / No

If so, describe_____

Has your child ever had a serious illness or operation? Yes / No

If so, describe _____

Has your child taken Phen-Fen or Redux? Yes / No

Is your child allergic to any medicine or anesthetic? Yes / No

If so, describe _____

Does your child have any of the following conditions?

Heart Problem	Yes / No	Kidney Problems	Yes / No	Venereal Disease	Yes / No
Coronary Insufficiency	Yes / No	Hepatitis	Yes / No	AIDS/HIV	Yes / No
Coronary Occlusion	Yes / No	Jaundice	Yes / No	Thyroid Disease	Yes / No
High Blood Pressure	Yes / No	Liver Disease	Yes / No	Nervous Disorder	Yes / No
Arteriosclerosis	Yes / No	Tuberculosis	Yes / No	ADD/ADHD	Yes / No
Stroke	Yes / No	Lung Problems	Yes / No	Autism	Yes / No
Heart Murmur	Yes / No	Persistent Cough	Yes / No	Seizures/Fainting Spells	Yes / No
Rheumatic Fever	Yes / No	Emphysema	Yes / No	Epilepsy	Yes / No
Disease	Yes / No	Sinus Problems	Yes / No	Cerebral Palsy	Yes / No
Sickle Cell Disease	Yes / No	Stomach Ulcers	Yes / No	Mental Disability	Yes / No
Bleeding Disorder	Yes / No	Diabetes	Yes / No	Hearing Disability	Yes / No
Excessive Bleeding	Yes / No	ammatory Rheumatism	Yes / No	Developmental Disability	Yes / No
Anemia	Yes / No	(painful/swollen joints)		Cleft Lip/Palate	Yes / No
Congenital Heart Disease	Yes / No	Arthritis	Yes / No	Premature Birth	Yes / No
Penicillin Allergy	Yes / No	Asthma	Yes / No	How many weeks? _____	
Latex Allergy	Yes / No	Hives/Rashes	Yes / No		

Does your child have any FOOD ALLERGY conditions? If so, what: _____

Does your child have any conditions not mentioned above? If so, what: _____

Adolescent Women:

Are you pregnant now or think you may be? Yes / No

Are you nursing? Yes / No

Are you taking oral contraceptive? Yes / No

_____ _____ _____

Name of parent/legal guardian (please print) **Signature** **Date**

_____ _____ _____

Review Medical History/Comments **Dentist Signature** **Date**