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.

☐ **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.**

Patient's name: _____ Patient's Date of Birth: _____

Medical History

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 _____
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	Inflammatory	Yes / No	Developmental	Yes / No
Anemia	Yes / No	Rheumatism	Yes / No	Disability	Yes / No
Congenital Heart	Yes / No	(painful/swollen joints)		Cleft Lip/Palate	Yes / No
Penicillin Allergy	Yes / No	Arthritis	Yes / No	Premature Birth	Yes / No
Latex Allergy	Yes / No	Asthma	Yes / No	How many weeks?	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**

Updated Info_____

PATIENT INFORMATION UPDATE

Patient Name: _____Male: _____Female:_____

Birthdate: _____ Social Security #:_____

Address: _____Apt#_____ City: _____ State: _____ Zip Code_____

Phone #:_____Work #:_____Ext:_____

Cell#:_____Email:_____

Emergency Contact Name: _____ Phone #:_____

Mother Name: _____ D.O.B._____ Father Name: _____ D.O.B:_____

❑ 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)*

PERSON RESPONSIBLE FOR ACCOUNT IF OTHER THAN PARENT

Name: _____

Birthdate: _____ Social Security #:_____

Address: _____City:_____ State: _____

Phone #:_____Work #:_____Ext:_____

Employer: _____Address:_____

Email: _____

PRIMARY INSURANCE POLICY HOLDER

Name: _____ Relationship to

patient:_____

Birthdate: _____ Social Security #:_____

Employer: _____Address:_____

Group/Policy #:_____Insurance Company: _____

SECONDARY INSURANCE POLICY HOLDER

Name: _____ Relationship to patient:_____

Birthdate: _____ Social Security #:_____

Employer: _____Address:_____

Group/Policy #:_____Insurance Company: _____