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

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 ____

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

If so, describe ____

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

Has your child taken Bisphosphonates? Yes / No

Does your child have any of the following conditions? (Please CIRCLE each one INDIVIDUALLY, YES or NO)

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	Yes / No
Rheumatic Fever	Yes / No	Emphysema	Yes / No	Spells	Yes / No
Sickle Cell Disease	Yes / No	Sinus Problems	Yes / No	Epilepsy	Yes / No
Bleeding Disorder	Yes / No	Stomach Ulcers	Yes / No	Cerebral Palsy	Yes / No
Excessive Bleeding	Yes / No	Diabetes	Yes / No	Mental Disability	Yes / No
Anemia	Yes / No	Inflammatory	Yes / No	Hearing Disability	Yes / No
Congenital Heart	Yes / No	Rheumatism (painful/	Yes / No	Developmental	Yes / No
Penicillin Allergy	Yes / No	swollen joints)		Disability	Yes / No
Latex Allergy	Yes / No	Arthritis	Yes / No	Cleft Lip/Palate	Yes / No
		Asthma	Yes / No	Premature Birth	Yes / No
		Hives/Rashes	Yes / No	How many weeks?	_________

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** **update 03/18**

PATIENT INFORMATION UPDATE

Patient Name: ____Male: _______Female:___________

Birthdate: ____________________________ Social Security #:______________________________________

Address: ____________________________Apt#________ City: _________ State: ______ Zip Code______

Phone#:___________________________Cell#:______________________________Email:____________________

Emergency Contact Name: _____________________________________ Phone #:______________________

❑ 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)*

Responsible Party Information

Who has legal custody of the patient? (If Applicable)

____Mother ____Father ___Legal Joint ____Other ______________________

Parents' Marital Status: _____Single _____Married _____Widowed _____Divorced ____Separated

Is Patient Adopted or Foster? ______Yes _____No (if yes, please provide court documents to management)

Parents'/Legal Guardian Name: ________________________D.O.B.__________________________

Parents'/Legal Guardian Name: ________________________D.O.B.__________________________

Address (If different) ____

City___________________________ State_______ Zip______________

Phone #:___________________________ 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: ______________________________