SAN CLEMENTE SMILES

BRANDON CURFEW, DMD

Child Patient Registration & Patient Medical History

Child's Name _____ (Last) _____ (First) _____ (MI)

Gender ◯ Male ◯ Female Birthdate _____

Mother - Contact Information

Name _____ (Last) _____ (First) Birthdate _____

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Email _____ (Please Print)

Cell # _____ Work # _____ Ext. _____

Home # _____

Employer _____ Occupation _____

Father - Contact Information

Name _____ (Last) _____ (First) Birthdate _____

◯ **Same Address**

Address _____ (Street) _____ (City) _____ (State) _____ (Zip)

Email _____ (Please Print)

Cell # _____ Work # _____ Ext. _____

Home # _____

Employer _____ Occupation _____

Primary DENTAL Insurance

Does the child have Dental Insurance? Yes ____ No ____

Insurance Company _____ Insurance Phone # _____

Policy Owner Name _____ Policy Owner Employer _____

Policy Owner Birthdate _____ Group ID # _____

Policy Owner Soc. Sec # _____ Relationship to Patient _____

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Secondary DENTAL Insurance (if applicable)

Does the child have Secondary Dental Insurance? Yes ____ No ____

Insurance Company _____ Insurance Phone # _____

Policy Owner Name _____ Policy Owner Employer _____

Policy Owner Birthdate _____ Group ID # _____

Policy Owner Soc. Sec # _____ Relationship to Patient _____

Dental History

Reason for seeking dental care at this time: _____

Mo/Year of last dental visit: _____ Reason: _____

Former Dentist or current DDS if visiting? _____ City / ST _____

How often does child brush? ◯ Once a day ◯ Twice a day ◯ Three times a day

How often does child floss? ◯ 1 ◯ 2 ◯ 3 → ◯ Day ◯ Week ◯ Month

How does child feel about dental treatment? ◯ Relaxed ◯ Uneasy ◯ Anxious ◯ Tense

Has child ever had Nitrous Oxide (laughing gas) during dental treatment? ◯ No ◯ Yes

Has child ever been requested to take antibiotics or other medications before/after a dental appointment? ◯ No ◯ Yes

Does/Has child ever had any of the following?

- ◯ Aching/Sensitive Teeth
- ◯ Bleeding Gums
- ◯ Grinding/Clinching
- ◯ Cold Sores
- ◯ Broken Filling
- ◯ Loose Teeth
- ◯ Bad Breath
- ◯ Dry Mouth
- ◯ Areas of Food Traps
- ◯ Difficulty Opening
- ◯ Gum Infection
- ◯ Oral Surgery
- ◯ Clicking/Popping Jaw
- ◯ Jaw Pain
- ◯ Orthodontics
- ◯ Periodontal Treatment
- ◯ None

Please indicate any dental concerns:

- ◯ Close gaps between teeth
- ◯ Straighten/even out front teeth
- ◯ Whiten teeth
- ◯ Change shape of teeth
- ◯ Replace missing teeth
- ◯ None
- ◯ Other

_____
Please explain

Continued on next page…

Medical History

Physician's Name _____

Is child currently under a physician's care? ◯ Yes ◯ No Reason? _____

Check the conditions to indicate if childe has or has had any of the following:

◯ Artificial Heart Valve
◯ Heart Disease
◯ Heart Murmur
◯ Mitral Valve Prolapse
◯ Pacemaker
◯ Heart Surgery
◯ Rheumatic / Scarlet Fever
◯ Artificial Joint
◯ Hepatitis A, B, C
◯ Liver Disease
◯ Kidney Disease
◯ HIV or AIDS
◯ Herpes
◯ High Blood Pressure
◯ Stroke
◯ Cancer
◯ Chemotherapy
◯ Radiation Therapy
◯ Glaucoma
◯ Asthma
◯ Sinus Trouble
◯ Tuberculosis
◯ Diabetes
◯ Epilepsy or Seizures
◯ Fainting/Dizzy Spells
◯ Psychiatric Treatment
◯ Chemical Dependency
◯ Bleeding Problems
◯ Circulatory Problems
◯ Headaches
◯ Back Problems
◯ None of the above

Has child taken any medications or injections in the last 3 months? If so, please list below.

_____ _____

_____ _____

List Allergies: ◯ Aspirin ◯ Latex ◯ Sulfa ◯ Codeine ◯ Penicillin ◯ None

List any other allergies:

_____ _____ _____

How did you hear about our office? ◯ Yelp (Reviews) ◯ Google (Reviews) ◯ Media Ad

◯ Other _____

◯ Friend/Family/Patient _____

Acceptance of Terms

I understand that the information I have provided is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

I hereby authorize the release of any information related to insurance claims. I consent to the examination by the doctor and I authorize payment of any insurance benefits to the office.

I understand financial arrangements must be made in advance. I am personally responsible for payment of all fees for dental services in this office regardless of insurance coverage. Payment is due when services are rendered. All emergency services or any dental service performed without prior financial arrangements must be paid for at the time services are performed.

◯ I have read and accept the above conditions

_____
Parent/Guardian Signature Date

_____
Doctor Signature Date

Thank you!