Peninsula Children's Dentistry

Purvi Zavery, DDS, MS

Creating A Lifetime of Healthy Smiles!

Child's Name _____ Nickname _____ Sex _____ DOB _____

Purpose of Visit _____ Concerns _____ Last Dental Visit _____

Name & age of siblings _____

Child's interests _____ Name of pet _____

Child's attitude toward previous dental care _____ Phobias _____

Does your child have any special needs? _____

Child's learning: slow ☐ average ☐ accelerated ☐ Child's previous dentist _____

Family's dentist _____ Who may we thank for referring you to us? _____

General Information

Father's Name _____ SS No. _____ DOB _____ DL No. _____

Mother's Name _____ SS No. _____ DOB _____ DL No. _____

Single ☐ Married ☐ Divorced ☐ Child resides with both parents ☐ Mother ☐ Father ☐

Home address _____ Phone No. _____

Father's employer _____ Phone No. _____

Business address _____ Mobile No. _____

Mother's employer _____ Phone No. _____

Business address _____ Mobile No._____

Email address _____ Person financially responsible for child's dental care _____

Are you the legal guardian? _____If No, then who is? _____

Relative not living with you (name, address & phone) _____

_____

The permission of parent or guardian is necessary for dental treatment of a minor. I give the dentist permission to use such measures as deemed necessary in his/her professional judgment to render the best dental treatment for my child. I understand, a late charge of 1.5% per month, and a monthly charge of $10.00 will be added to unpaid balances over 60 days past due and where appropriate, credit bureau reports may be obtained.

SIGNATURE _____ Relationship _____ Date _____

Insurance Information

Do you have dental insurance for this child? __

Father's Insurance: Name of insurance company _____ Group No. _____

Address of insurance company _____ Zip _____

Mother's Insurance: Name of insurance company _____ Group No. _____

Address of insurance company _____ Zip _____

I hearby authorize payment to the above named dentist of the group dental benefits, otherwise payable to me but not to exceed the charges shown on the claim. I understand I am financially responsible for any charges not covered by my insurance or by this authorization.

SIGNATURE _____ Relationship _____ Date _____

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Child's Name _____ _____DOB _____

Child's pediatrician _____ Phone No. _____ Last Physical _____

Is your child under physician's care now? ___ Reason _____ Has your child received all immunizations? ___

Is your child taking any medication? ___ What kind _____ Reason _____

Is your child allergic to any medications? ___ Please list _____

Has your child ever been hospitalized? ___ Reason _____

Any allergic reactions to: eggs ☐ soy ☐ foods ☐ pollen ☐ dust ☐ latex ☐ animals ☐ other _____

Habits: finger/thumb sucking ☐ pacifier ☐ lip sucking ☐ mouth breathing ☐ snoring ☐ teeth grinding ☐

Has your child had any injuries to teeth, mouth, or head? ___ Describe _____

Has your child had a history or difficulty with any of the following:

☐ Premature birth	☐ Earaches	☐ Speech	☐ Nosebleeds
☐ Heart	☐ Kidney	☐ Hearing	☐ Asthma
☐ Seizures	☐ Bleeding	☐ Brain injury	☐ Liver
☐ Immune disorder	☐ Cerebral Palsy	☐ Bruising	☐ Bone disorder
☐ Allergy to medication	☐ Anemia	☐ Bladder	☐ Rheumatic fever
☐ Cancer or malignancies	☐ Motion sickness	☐ Fainting or dizziness	☐ Diabetes
☐ Delayed development	☐ Emotional problems	☐ Tuberculosis	☐ Hepatitis
☐ Autism	☐ ADD/ADHA	Any medical condition not on this form _____	

How may we help to make this visit a positive experience for your child?

_____
_____
_____
_____
_____

SIGNATURE _____ Relationship _____ Date _____

Please do not write below this line

Doctor's Comments:

_____
_____
_____
_____
_____