

We would like to welcome you and your child to our office

Please tell us about your child

Patient Name
Patient Social Security Number

Age Birthdate
 Sex M or F Weight

Is your child here for a specific reason or in pain? If so, for what?

Medical Doctor
 Address

Telephone
 FAX

Names of other children in your family
 (First name, Last name, Age)

Review of Health History

- | | | |
|--------------------------|--------------------------|---|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Has your child been to the hospital or had a serious injury in the last six months? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your child presently under the care of a physician for any medical problem? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your child currently taking any medication? |
| <input type="checkbox"/> | <input type="checkbox"/> | Is your child allergic to any food, medicines (ie: penicillin), or LATEX? |
| <input type="checkbox"/> | <input type="checkbox"/> | Any immunocompromized conditions, organ transplant, ARC, or HIV? |
| <input type="checkbox"/> | <input type="checkbox"/> | For women only, pregnant? If so, how many months? |

Office Use	
.....	
.....	
.....	
Doctor's Initials	Date

Does your child now have or has your child ever had a history of any of the following?

- | | | | | | |
|--------------------------|--------------------------|---|--------------------------|--------------------------|--|
| YES | NO | | YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Allergies to Medications, Peanuts, Latex, etc | <input type="checkbox"/> | <input type="checkbox"/> | Eye Problems / Glaucoma |
| <input type="checkbox"/> | <input type="checkbox"/> | Anemia | <input type="checkbox"/> | <input type="checkbox"/> | Genetic Syndrome |
| <input type="checkbox"/> | <input type="checkbox"/> | Asthma / Other Lung Disease | <input type="checkbox"/> | <input type="checkbox"/> | Hearing / Speech Problems |
| <input type="checkbox"/> | <input type="checkbox"/> | Autism / Mental / Emotional Problems | <input type="checkbox"/> | <input type="checkbox"/> | Heart Disease / Murmur / Defect / Surgery |
| <input type="checkbox"/> | <input type="checkbox"/> | Autoimmune Disease (AIDS) | <input type="checkbox"/> | <input type="checkbox"/> | Hemophilia or Bleeding Problems / Bruises Easily |
| <input type="checkbox"/> | <input type="checkbox"/> | Birth Defects / Congenital Disease | <input type="checkbox"/> | <input type="checkbox"/> | Hepatitis or Liver Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Bone or Joint Problems or Surgery | <input type="checkbox"/> | <input type="checkbox"/> | Herpes / Venereal Disease |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer / Malignancies / Leukemia | <input type="checkbox"/> | <input type="checkbox"/> | Kidney Disease or Bladder Condition |
| <input type="checkbox"/> | <input type="checkbox"/> | Cerebral Palsy | <input type="checkbox"/> | <input type="checkbox"/> | Premature Birth |
| <input type="checkbox"/> | <input type="checkbox"/> | Chronic Tonsil / Adenoid / Ear Infections | <input type="checkbox"/> | <input type="checkbox"/> | Rheumatic Fever |
| <input type="checkbox"/> | <input type="checkbox"/> | Convulsions / Seizures / Epilepsy / Fainting | <input type="checkbox"/> | <input type="checkbox"/> | Sickle Cell Anemia |
| <input type="checkbox"/> | <input type="checkbox"/> | Developmental Delay | <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis (TB) |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | <input type="checkbox"/> | Other |

If you answered yes for any question above, please explain

Is there anything of importance in your child's health history that has not been asked about or anything else that you think we should know about your child? If so, what?

Review of Dental History

Would you describe your child as: shy / timid frightened apprehensive outgoing other

How would you expect your child to behave in our dental office? Describe

Has your child had problems with prior dental treatment? If yes, please describe

Has your child ever been sedated for dental treatment? If yes, please describe

How did you find out about our office? (Please Check All That Apply) Discovery Dental Group Website: www.Pediatricdentistsf.com

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Doctor Oogle.com | <input type="checkbox"/> Yahoo.com / Local DDS Lists | <input type="checkbox"/> AT&T – SBC Yellow Pages.com | <input type="checkbox"/> Verizon - SmartPages.com |
| <input type="checkbox"/> Dentists4kids.com | <input type="checkbox"/> Google.com | <input type="checkbox"/> AT&T – SBC Yellow Pages Directory | <input type="checkbox"/> City Search.com / S.F. |
| <input type="checkbox"/> Insurance Website, which one? | <input type="checkbox"/> Other | | |

If a friend, relative, or Doctor referred you to our office, whom may we thank for the referral?

- | | |
|---|---|
| <input type="checkbox"/> Friend or Relative | <i>Please indicate their name and address below</i> |
| <input type="checkbox"/> Medical Office | |
| <input type="checkbox"/> Dental Office | Name |
| | Address |

FAMILY INFORMATION AND FINANCIAL RESPONSIBILITY

Father / Stepfather / Legal Guardian Information

Name DOB

SSN # Email

Driver's License State # Exp

Home Address Apt#

City State ZIP

Home # Cellular #

Is it ok to contact Father at his Cellular Number? Yes No

Employer

Address

City State ZIP

Business # Ext

Occupation

Mother / Stepmother / Legal Guardian Information

Name DOB

SSN # Email

Driver's License State # Exp

Home Address Apt#

City State ZIP

Home # Cellular #

Is it ok to contact Mother at her Cellular Number? Yes No

Employer

Address

City State ZIP

Business # Ext

Occupation

Patient lives with Father

Patient lives with Mother

Person responsible for this account

Father

Mother

Other

Person responsible for scheduling appointments

Father

Mother

Other

Office Use Only

Office Use Only

Does the patient have any insurance coverage? Yes / No

Name of Insured

Social Security Number

Name of Insurance Carrier

Group Number

Contact Person (Friend or Relative WITH DIFFERENT PHONE NUMBERS THAN ABOVE)

Name

Relationship

Home # Cellular #

Work #

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform the office of any change in my child's health and/or medications, family information, financial responsibility, or insurance coverage. Further, I will not hold Fred C. Haeberlein, APDC and the Discovery Dental Group, or any member of our staff responsible for any errors or omissions that I may have made in completion of this form. The practice of dentistry involves treating the whole person. If our Doctors determine that there may be a potentially medically compromised situation, medical consultation may be needed prior to starting dental treatment. I authorize the Fred C. Haeberlein, APDC to contact my physician.

Signature of Parent or Legal Guardian _____

Date _____

RECALL OR EMERGENCY UPDATE: Have there been any changes in your child's health history since you originally filled out this form? If so, please indicate changes in box below. ↓

<i>Date</i>	<i>Parent Signature</i>	Changes	<i>DDS</i>
<i>Date</i>	<i>Parent Signature</i>	Changes	<i>DDS</i>
<i>Date</i>	<i>Parent Signature</i>	Changes	<i>DDS</i>

Questionnaire Update: An updated and completely new Get Acquainted Questionnaire is required every 12 months as per the American Academy of Pediatric Dentistry Standard of Care. This is required for the benefit and safe treatment of your child and for completeness of his/her records.

Keeping Your Appointments: If you are unable to keep your appointment, **you need to contact our office during regular office hours.** Failure to give adequate notice may result in a Missed Appointment Fee. No charge will be made for rescheduling your appointment if a 48 hour notice is given to one of our reception staff, so that your child's reserved time can be given to another patient. **We do not consider a message left on or with the answering service as 48 hour notice. You need to call and speak with one of our reception staff during normal business hours.** A family history of excessive cancellations without 48 hour notice, missed appointments, or repeated unsuccessful attempts to arrange for an appointment will be cause for discontinuation of treatment for the entire family.