Welcome Aboard!

Our ship is a friendly one! We try to make every child's visit a pleasant and educational experience. Our mission is to help guide your child to a lifetime of great smiles by working together with you in teaching good home care habits and the very latest concepts in preventive care.

We take pride in our office sterilization and infection control program which will always meet or exceed mandated regulatory standards.

About your child

Child's Name

Nickname

Age ☐M ☐F Date of birth

School Grade

Reason for visit

Referred to this office by (we wish to thank them.)

Medical History

Child's physician

Physician's phone

Date last saw physician (month/year)

1. Is your child presently under the care of a physician for any medical problem?

☐Y ☐N What?

2. Is your child currently taking any medication?

☐Y ☐N What?

3. Has your child ever been hospitalized or had surgery?

☐Y ☐N For what?

4. Is your child allergic to any food or medicine?

☐Y ☐N What?

Has your child had history of? **(CHECK IF YES)**

- ☐ Heart trouble or murmurs
- ☐ Rheumatic fever
- ☐ Allergies
- ☐ Drug sensitivities
- ☐ Asthma
- ☐ Diabetes
- ☐ Kidney/liver involvement
- ☐ Tuberculosis
- ☐ Hepatitis
- ☐ Headaches
- ☐ Brain injury
- ☐ Seizures/convulsions
- ☐ Epilepsy
- ☐ Bleeding problems
- ☐ Blood disorders
- ☐ HIV positive/AIDS
- ☐ Learning disorders
- ☐ **NONE**

Is there anything else regarding your child's physical, mental or EMOTIONAL health that you feel we should know? ☐Y ☐N What?

Dental History

Child's first dental visit? ☐Y ☐N

Previous dentist

City Date of last visit

Any injury to your child's teeth or jaws? (falls, blows, chips, etc.) ☐Y ☐N

History of? ☐Thumb sucking ☐Lip sucking ☐Finger sucking ☐Nail biting ☐Pacifier

Has your child experienced any unfavorable reaction from previous medical or dental care? ☐Y ☐N

Explain

How do you think your child will behave toward the dentist?

Age of child when discontinued bottle or nursing.

Name of family dentist

City

Preventive Dental History

How often does child brush?

Is toothbrushing supervised? ☐Y ☐N

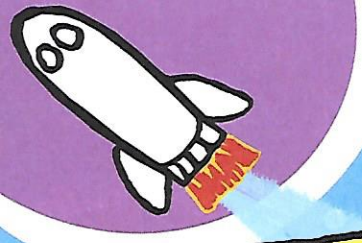
By whom? When?

Is dental floss used? ☐Y ☐N

Does your child receive (Check)

- ☐ Fluoride in vitamins
- ☐ Fluoridated water
- ☐ City water
- ☐ Fluoride tablets/drops
- ☐ Bottled water
- ☐ None of the above

SMILE AND THE UNIVERSE WILL SMILE WITH YOU!



CHILD

Residence address (street)

City Zip Phone

FATHER

Father's full name

Soc. sec. no. Birth date

Address if different

Occupation

Employed by

Business address (street)

City Zip Phone

Name of dental insurance co.

Group no. Employee no.

Cell phone

E-Mail address

MOTHER

Mother's full name

Soc. sec. no. Birth date

Address if different

Occupation

Employed by

Business address (street)

City Zip Phone

Name of dental insurance co.

Group no. Employee no.

Cell phone

E-Mail address

BROTHERS & SISTERS

First names of the child's brothers & sisters and their ages:

Has any member of your family been a patient in this office before? ☐Y ☐N If yes, name

FINANCIAL STUFF

If the family is not living together, the parent bringing the child in is responsible for the child's account.

I hereby authorize Dr. Eunha Cho, Dr. Betsy Kaplan, Dr. Cathy Chien, Dr. Ahsan Raza, Dr. Amy Buehler, and/or their associates to perform any and all dental treatment for my above-named child and consent to acceptable methods and pharmacological agents necessary to complete his/her dental care. This consent shall remain in effect until canceled.

Signature

Relationship to child Date

PLEASE NOTE: Payment is expected for service rendered at the time of the first visit, financial arrangement for subsequent treatment may be made following the diagnosis. Thank you.

A fee may be assesed for missed appointments unless the office is notified 24 hours before appointment.

We are proud of our patients.. and have lots of fun here! With your permission we would love to share that fun by adding your child's photo on our social media page. For your privacy we will not add your child's name.

I give Children's Dental Group permission to display my child's photo.

X_____

I consent to the dental practice using my cell phone number to 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: ( ) _____.

Print Name: _____ Date: _____

Signature: _____

Thank you for completing this form. Your answers will be of great value in aiding us to a better understanding of your child. Please feel free to ask if you or your child have any special concerns or questions.