Welcome to the Office of Dr. Ivette Diaz

We are honored that you have selected us to provide dental care for your children. Please fill out the following form to help us serve you.

RESPONSIBLE PARTY

Full Name: _____ Relationship to Patient: _____

Phone numbers: Cell: _____ Work: _____

Email address: _____

Spouse or other guardian: _____ Relationship to Patient: _____

Phone Numbers: Cell: _____ Work: _____

Email address: _____

Home Address: _____ Home Phone number: _____

_____

Whom may we thank for referring you to our office? _____

Our office will only send email and text messages for appointment confirmations. We do not send SPAM mail! Please let us know your preferred method of contact:

Primary Email address: _____ Primary Text phone number: _____

POLICY HOLDER

Full Name: _____Birthdate: _____Employer: _____

Insurance Company: _____ Ins. Phone Number: _____

ID# or SSN: _____ Group Number: _____

Claims Address: _____

As a courtesy, we will verify and file your insurance claim for you. It is important that we have a copy of your insurance card. Please take a picture of the front and back of your insurance card and email it to ins@abc123pd.com.

PEDIATRICIAN

Pediatrician's name: _____ Phone Number:_____

PHARMACY

Name: _____ Number:_____

CHILDREN

Name: _____ Birthdate: _____

Name: _____ Birthdate: _____

Name: _____ Birthdate: _____

Name: _____ Birthdate: _____

Name: _____ Birthdate: _____

Name: _____ Birthdate: _____

I hereby authorize Dr. Ivette Diaz to perform any services needed for my child/children such as exam, x-rays, cleaning, fluoride, etc as deemed necessary for diagnosis of their dental condition.

ABC123 Pediatric Dentistry will file the insurance claim for you. Please be advised that we can only file the claim with the information you have provided for us. I authorize release of any information related to this claim. I realize that I am ultimately responsible for all costs of dental procedures rendered. I hereby authorize for my insurance benefits to be paid directly to Dr. Ivette Diaz.

After the initial examination, we will give you an estimate of fees to cover any service your child/children may need. At that time, financial arrangements will be made prior to any treatment being performed.

I authorize ABC123 Pediatric Dentistry and Dr. Ivette Diaz to contact third party providers as necessary and discuss patient information as needed for completion of medical history details and/or dental treatment.

Signature: _____Print Name: _____Date: _____

Authorization

I authorize the following people to bring any of the children listed above to their dental visit. I consent for them to make decisions for their dental visit and in the case of an emergency. I understand that the responsible party will still be responsible for all costs of treatment. Must be 18 years old or older.

Name: _____ Birthdate: _____Relationship: _____

Name: _____ Birthdate: _____Relationship: _____

MEDICAL HISTORY for (child's name): _____

When was the child's last visit to the pediatrician? _____
Are your child's vaccines up to date? _____

Does this child see any other doctor besides the pediatrician? _____

If so, who, what specialty, and for what condition?

_____

Does your child have any allergies to medications? _____

Does your child have food or seasonal allergies? If so, please list:

_____

Is your child **allergic to latex**? _____

Has the patient **ever** had any of the following? (check all that apply)

- o ADHD/ADD
- o Allergies to anything not listed above
- o Autism
- o Asthma
- o Bleeding Problems
- o Anemia
- o Blood Transfusion/ Transfusion de Sangre
- o Bruise Easily
- o Cancer
- o Cerebral Palsy
- o Cold Sores or Fever Blisters/
- o Congenital Heart Problems
- o Pregnant
- o Diabetes
- o Dizziness or Fainting
- o Down's Syndrome
- o Eating Disorder
- o Epilepsy or Seizures
- o Heart Murmur
- o Herpes
- o High/Low Blood Pressure/
- o HIV-AIDS
- o Hypoglycemia or Hyperglycemia
- o Jaw Joint Pain
- o Kidney or Liver Disease
- o Lung Disease
- o Psychiatric Care
- o Radiation/Chemotherapy
- o Rheumatic Fever
- o Transplant
- o Tuberculosis
- o Ulcers or Stomach Problems
- o Use Tobacco

- o None

Does your child have any condition or problem not listed above? _____

Is your child currently taking any medications? If so, please list each medication

_____

Has your child been hospitalized under a physician's care in the last two years? If so, why?

_____

Does your child require antibiotics before dental treatment? _____
Has your child ever had a surgery under general anesthesia? _____

Was there an adverse reaction? _____

DENTAL HISTORY for (child's name): _____

Reason for this visit? _____

Is this your child's first dental visit? If not, what is the date of their last visit ?_____

Name of former dentist _____ Type of dentist _____

Phone _____ Do we need to get previous x-rays?_____

Did former dentist inform you that your child has cavities? _____

Has your child ever been sedated to have dental work done? _____

If so, was the sedation successful? Were they able to complete the planned dental treatment?

_____

What medications were used? _____

Has your child had IV Sedation or General Anesthesia for dental treatment? _____

Has your child ever had any injuries to his or her teeth, mouth, head or jaw? If yes, please describe:

_____

Has your child had any bad dental or medical experiences in the past? If yes, please explain:

_____

How can we make this a more positive experience for your child?_____

Does your child participate in sports? If so, which? _____

Was your child breast fed, bottle fed, or both and until what age? _____

Does your child brush twice a day? _____ Does an adult assist with brushing? _____

Does your child floss daily? _____Does an adult assist with flossing? _____

Does your child have any of the following mouth habits?

- Mouth Breathing
- Teeth Grinding
- Snores
- Pacifier
- Finger or Thumb Sucking

- None

Is there anything you would like to discuss with Dr. Ivette Diaz not in front of your child?

_____