



# 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: \_\_\_\_\_

School District: \_\_\_\_\_

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](mailto:ins@abc123pd.com).**

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## **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: \_\_\_\_\_



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## 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:

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Is your child **allergic to latex**? \_\_\_\_\_

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

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

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## **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?