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.

____

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 consent to photographs being taken of my child(ren) at ABC123 Pediatric Dentistry. I have been informed that the purpose of these photographs includes any of the following: identification of the patient, chart profile photo, training purposes for staff and social media.

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)

- ○ 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
- o 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? ____

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?