VALLEY VIEW DENTAL CARE

Eric M. Barrientos, D.D.S.

471 Castro Street, Mountain View, CA 94041

About Your Child

Today's Date: ________/______/________

Child's Name: ______________________________

Last First MI

Child's Gender: (circle) Male Female

Child's Birthdate: ________/_____/________

Age:__________ **Grade:** ____________

School: ______________________________

Child's Home Phone: (_____)_____________

Child's SS#: ___________________________

Child's Address:_______________________

Home Address

____

City State ZIP

Referred by: ___________________________

(if doctor, please give address and phone number)

____

____

Insurance Info

Primary Dental Insurance

Co. Name______________________________

Address:______________________________

____

City State ZIP

Phone #:(_______)______________________

Insured's ID#:__________________________

Group ID# (Plan, Local, or Policy #)____________

Insured's Name:________________________

Relation:______________________________

Date of Birth: __________/_______/_______

Insured's Employer: ____________________

Seconday Dental Insurance

Co. Name______________________________

Address:______________________________

____

City State ZIP

Phone #:(_______)______________________

Insured's ID#:__________________________

Group ID# (Plan, Local, or Policy #)____________

Insured's Name:________________________

Relation:______________________________

Date of Birth: __________/_______/_______

Insured's Employer: ____________________

Child's family Information

Who is accompanying the child today?

____

FULL NAME (IF OTHER THAN PARENT)

Relation: ______________________________

Do you have Legal Custody of this Child? (circle)

YES NO

How many Brothers/Sisters? __________

Ages: _______ _______ _______ _______ _______

Mother's Name:__________________________

Circle one: Guardian or Step Mother

Do Not Fill if Same as Child's

____

Home Address

____

City STATE ZIP

(_____)_______________ (_____)_______________

Home Phone Work Phone

__________________________ ______/____/_____

Mother's social security Date of Birth

Driver's License:_________________________

Employer:_______________________________

____

Employer's address

____

City STATE ZIP

Father's Name:__________________________

Circle one: Guardian or Step Father

Do Not Fill if Same as Child's

____

Home Address

____

City STATE ZIP

(____)_________________ ( )_______________

Home Phone Work Phone

______________________ ________/_____/_______

Father's Social Security Date of Birth

Driver's License:_________________________

Employer:_______________________________

____

Employer's address

____

City STATE ZIP

Account Information

Person Ultimately Responsible for Account

Name: ________________________ **Relation to Child:** ____________________

Billing Address:____

City State ZIP

_________________________ _________/_____/_______ ___________________________

Social Security Date of Birth Drivers License #

( )_______________________ ___________ **Payment Method: (circle) CASH CHECK Credit Card**

Cell Phone # Credit Card # __________________________ **EXP.** ____/_____

___________ **I heareby authorize assignment of my rights and benefts directly to the I am solely responsible**

Initial **for any balance not paid by my insurance company (if offered at this office).**

Child's Dental Information

Please indicate [X] for the following questions:

Reason for Visit: [ ] Exam [ ]Emergancy [ ]Consultation [ ]Cleaning [ ]Treatment

Is Child in Pain? [ ] Yes [ ]No If yes, how long? ______________________

Please indicate [X] any of the following problems:

[ ]Discomfort,clicking or popping jaw [ ]Lost/Broken Filling(s) [ ] Stained Teeth
[ ]Red,swollen or bleeding gums [ ]Teeth Grinding [ ] Locking Jaw
[ ]Sensitive tooth, teeth or gums [ ]Rining in Ears [ ]Bad Breath
[ ]Blisters/sores in or around the mouth[ ]Broken/Chipped Tooth [ ]Loose Tooth
[ ]Other(s): ____

Does child require pre-medication? [ ]Yes [ ]No [ ] I Don't Nnow

Previous Dentist:____________________________________ Phone number:(_____)______________________

Last Dental Exam: _________/_____/__________ Last Dental X-rays: _________/_____/__________

Times a day child brushes? _________ Times a week child flosses? ________

Is the child's water fluoridated? [ ]Yes [ ]No

How would you rate the child's smile? (circle) WORST 1 2 3 4 5 6 7 8 9 10 BEST

Child's Medical History

Is Child taking any of the following medications?

[ ]Pain killers (ASPIRIN) [ ]Ritalin [ ]Stimulants [ ]Blood Thinners [ ]Tanquilizers [ ]Insulin
[ ]Muscle relaxers [ ]Others:____

Child's Physician: ____ (_____)_____________________

DOCTOR'S NAME OR CLINIC NAME PHONE NUMBER

____

ADDRESS CITY STATE ZIP

Last Medical Exam: __________/______/__________

Does Child have or ever had any of the following diseases, medical conditions or procedures? (circle)

Y N Heart Murmur	Y N Tonsillitis	Y N High/Low Blood Pressure	Y N Rheumatic Fever
Y N Respiratory Problems	Y N Artificial Heart Valves	Y N asthma/Difficulty Breathing	Y N Hepatitis
Y N Blood transfusion(s)	Y N Cognetial Heart Defect	Y N Artificial Bones/Joints/Implants	Y N Scarlet Fever
Y N Leukemia/Anemia	Y N HIV+/AIDS/ARC	Y N Liver/Kidney/Organ Problems	Y N Surgeries/Operat.
Y N Diabetes/Hypoglcemia	Y N Tuberculosis TB	Y N Psychiatric Problems	Y N Hemophilia
Y N Chemotherapy	Y N Abnormal Bleeding	Y N Hyper Active/ ADD	Y N Cleft Lip/Palate
Y N Jaw Problems TMJ/TMD	Y N Fainting/seizures/epilepsy	Y N Hearing Problems	Y N Birth Defects
Y N Cerebral Palsy			

Please list any ther medical condition(s) child has or ever had: ______________________________________

____

Is Child allergic to: [ ]Latex [ ]Penicillin/Amoxicillin [ ]Tetracycline [ ]Dental Anesthetics (Novocaine)
[ ]Aspirin [ ]Food Allergies [ ]Other(s):____________________________________

Please rate the child's general health from 1-10:_________Does child wear contact lenses? [ ]Yes [ ]No

Has this child ever taken the drug Ritalin? [ ]No [ ]Yes/How Long? _________ Child's Blood Type: ______

Does child have any of the following: [ ]Thumb/finger sucking [ ]Tongue Thrusting/Sucking
[ ]Heavy Snoring [ ]Mouth Breathing [ ]Lip Sucking/Biting

*We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

*Our policy requires payment in full for all services rendered at the time of visit, unless other arrangeme -nt have been made with the business manager. If account is not paid within 90 days of the date of service, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

*I authorize the staff to perform any nexessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

*I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

____ _________/____/_______

Signature Date

circle one: Parent or Guardian Other:______________________