Welcome

Valley View Dental Care
471 Castro Street
Mountain View, CA 94041
(650) 965-0580

Today's Date: _____

About Your Child

Child's Name: _____
Last First MI
Child's Nickname: _____
__Boy __Girl Child's Birth date: _____ Age: ___
Child's SS#: _____
Child's Address: _____
_____
City State ZIP
Child's Home Phone #: _____
School: _____ Grade: _____
Referred By: _____
(If doctor, please give address & phone number.)
_____

Insurance Information

Primary Dental Insurance
Co. Name: _____
Address: _____
_____
City State ZIP
Phone #: _____
Insured's ID#: _____
Group # (Plan, Local, or Policy #):
_____
Insured's Name: _____
Relation: _____
Date of Birth: _____
Insured's Employer: _____
Does either policy cover orthodontics?
___Yes ___No

Secondary Dental Insurance
Co. Name: _____
Address: _____
_____
City State ZIP
Phone #: _____
Insured's ID#: _____
Group # (Plan, Local, or Policy #):
_____
Insured's Name: _____
Relation: _____
Date of Birth: _____
Insured's Employer: _____

Child's Family Information

Who is accompanying this child today?
_____ _____
Full Name (If other than parent) Relation to Child
Do you have Legal Custody of this Child? ___Yes ___No
How many Brothers/Sisters? _____ Age(s):_____
Mother's Name: _____
__ Step Mother __Guardian
_____
Home Address (__ Check if same as child's)
_____
City State Zip
Home Phone: _____
Work Phone: _____
_____ _____ _____
Mother's SS # Date of Birth Mother's Drivers Lic.#
Employer: _____ How Long? _____
Employer's Address: _____
_____
City State Zip
Father's Name: _____
__ Step Father __Guardian
_____
Home Address (__ Check if same as child's)
_____
City State Zip
Home Phone: _____
Work Phone: _____
_____ _____ _____
Father's SS # Date of Birth Father's Drivers Lic.#
Employer: _____ How Long? _____
Employer's Address: _____
_____
City State Zip

Account Information

Person ultimately responsible for account
Name: _____
Relation to child: _____
Billing Address: _____
_____
City State ZIP
SS #: _____ Date of Birth: _____
Driver's License #: _____
Work Phone #: _____ Cell Phone #: _____
Payment Method: (Check One) ___Cash ___Check ___Credit Card
_____
If Credit Card, Enter card # above Card Expiration Date

_____
(Initials) I hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Please continue on next page →

Child's Dental Information

Reason for today's visit: ___ Exam ___ Emergency ___ Consultation
Is Child in pain? ___ No ___ Yes For how long?_____
Please indicate (check) any of the following problems:

__ Discomfort, clicking or popping in jaw __ Lost/Broken Filling(s) __ Stained Teeth
__ Red, swollen or bleeding gums __ Teeth grinding __ Locking Jaw
__ Sensitive tooth, teeth or gums __ Ringing in Ears __ Bad breath
__ Blisters/Sores in or around the mouth __ Broken/Chipped tooth __ Loose Tooth
__ Other: _____

Does child require pre-medication? ___Yes ___ No ___ Don't Know
Previous Dentist: _____ Phone: _____
Date of Last Dental exam: _____ Date of Last Dental X-rays: _____
How many times a day does child brush? _____ Times a week child flosses? _____
What type of tooth brush bristles do you use? ___ Soft ___ Medium ___ Hard
How would you rate your child's smile? (Circle Below)
(Worst) 1 2 3 4 5 6 7 8 9 10 (Best)

Child's Medical History

Is Child taking any of the following medications? (Check all that apply below)

__ Pain Killers (including aspirin) __ Ritalin __ Stimulants __ Blood Thinners
__ Muscle Relaxers __ Insulin __ Tranquilizers __ Other: _____
Child's Physician: _____ Phone #: _____
Doctor's Name or Clinic Name
_____ Last Medical Exam: _____
Address City State ZIP

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

Y N Heart Murmur
Y N Rheumatic fever
Y N Artificial Heart Valves
Y N Congenital Heart defect
Y N Scarlet Fever
Y N Surgeries/Operations
Y N Cancer/Tumors
Y N Chemotherapy
Y N Jaw Problems TMJ/TMD
Y N Hearing Problems
Y N Tonsillitis
Y N Respiratory Problems
Y N Asthma/Difficulty Breathing
Y N Blood Transfusion(s)
Y N Leukemia/Anemia
Y N Diabetes/Hypoglycemia
Y N Hemophilia
Y N Abnormal Bleeding
Y N Cleft Lip/Palate
Y N Birth Defects
Y N High/Low Blood Pressure
Y N Hepatitis
Y N Artificial Bones/Joints/Implants
Y N Liver/Kidney/Organ Problems
Y N HIV+/AIDS/ARC
Y N Tuberculosis TB
Y N Psychiatric Problems
Y N Hyper Active/ADD
Y N Fainting/Seizures/Epilepsy
Y N Cerebral Palsy

Please list any other medical condition(s) child has or ever had: _____
_____
Is Child allergic to (check all that apply):
___ 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 this child do any of the following? (Check all that apply below)
___ 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 arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collected your account.
- I authorize the staff to perform any necessary 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 _____
Check One: ___Parent or Guardian ___Other