

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.)

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

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: _____

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