22106 E Country Vista Dr., Suite D
Liberty Lake, WA 99019

Simonds Dental Group

(509) 893-1119
www.LibertyLakeDental.com

Thank you for trusting your child with our office. In order to serve he or she properly, please answer all questions on BOTH sides, so that we may diagnose their oral health as accurately as possible. All information will be kept strictly confidential.

CHILD'S NAME_____PREFERRED NAME _____

❑ Male ❑ Female Birthdate_____/_____/_____ Age_____Home Phone No. (_____)_____

Father's Name_____ SSN_____/_____/ _____ Birthdate_____/_____/ _____

Mailing Address_____ City_____ State____ ZipCode _____

Home Phone No. (_____) _____ Work Phone No. (_____) _____Cell Phone No. (_____)_____

Email_____ **Best number to contact you?** ❑ Home ❑ Cell ❑ Work

Father's Occupation_____Employer_____

❑ *Married* ❑ *Single* ❑ *Divorced* ❑ *Separated* ❑ *Widowed*

Mother's Name_____ SSN_____/_____/ _____Birthdate_____/_____/ _____

Mailing Address_____ City_____State____ ZipCode _____

Home Phone No. (_____) _____ Work Phone No. (_____) _____Cell Phone No. (_____)_____

Email_____ **Best number to contact you?** ❑ Home ❑ Cell ❑ Work

Mother's Occupation_____Employer_____

❑ *Married* ❑ *Single* ❑ *Divorced* ❑ *Separated* ❑ *Widowed*

With whom does this child reside? _____

Payment Is Expected At Time Of Each Visit

Please Check Method of Payment

❑ Cash ❑ Check ❑ Bankcard ❑ Insurance

Person responsible for this child's account:_____Phone No. (_____) _____

WHOM MAY WE THANK FOR REFERRING YOU?_____

Primary Dental Insurance

Employee _____

Relationship to Patient _____

Employer _____

Insurance Co._____Group#_____

Insurance Phone No. _____

Employee's SSN _____

Subscriber D.O.B. _____

Secondary Dental Insurance

Employee _____

Relationship to Patient _____

Employer _____

Insurance Co._____Group#_____

Insurance Phone No. _____

Employee's SSN _____

Subscriber D.O.B. _____

I have been given and understand the Simonds Dental Group HIPPA Notices of Privacy Practices Act for my child.

Signature_____Date _____

(Turn Page Over)

Dental History

Is this your child's first dental visit? ❑ Yes ❑ No
Date of last dental visit_____
Previous Dentist's Name and Location _____
_____
Has your child ever had a bad dental experience? ❑ Yes ❑ No
Does your child feel nervous about having dental treatment? ❑ Yes ❑ No

Have there been any injuries to your child's teeth or jaws? Falls/Blows/Chips/etc.? ❑ Yes ❑ No
Does your child take antibiotics for a health condition before each dental visit? ❑ Yes ❑ No
Does your child receive fluoride in vitamins, tablets or water? ❑ Yes ❑ No
Has your child been seen by an orthodontist? ❑ Yes ❑ No

Health History

Is your child having any pain or discomfort at this time? ❑ Yes ❑ No
Has your child been hospitalized or seen a Medical Doctor in the past 2 years? ❑ Yes ❑ No
If so, for what condition? _____
_____

Does your child have a personal Physician? ❑ Yes ❑ No
Physician's Name: _____
Date of last visit: _____
Reason for visit: _____

Is your child currently taking any prescriptions, over the counter drugs or herbal supplements? ❑ Yes ❑ No
If so, please list and include the reason for taking:
_____
_____
_____

Please list any serious medical condition(s) that your child currently has or has had in the past: _____
_____
_____
_____

Please Check any of the following which your child has now or has had in the past.

- ❑ **No medical conditions**
- ❑ Angina Pectoris (Chest Pain)
- ❑ Heart Disease/Attack/Stroke
- ❑ Heart Failure
- ❑ High/Low Blood Pressure
- ❑ Congenital Heart Defect
- ❑ Heart murmur/Rheumatic Fever
- ❑ Heart Surgery
- ❑ Heart Pacemaker
- ❑ Artificial Heart Valve
- ❑ Diabetes, Type I ❑ II ❑
- ❑ Blood Transfusion/Anemia
- ❑ Sickle Cell Disease
- ❑ Bruise Easily
- ❑ Hemophilia/Blood Disorder
- ❑ Liver Disease/Yellow Jaundice
- ❑ Kidney Failure/Dysfunction
- ❑ Thyroid Disease/Condition
- ❑ Ulcers
- ❑ Glaucoma
- ❑ Cosmetic surgery_____
- ❑ Chemotherapy for Cancer
- ❑ X-ray Treatment for Cancer
- ❑ Tuberculoses (TB)
- ❑ Arthritis/Rheumatism/Lupus
- ❑ Cortisone Medicine/Steroids
- ❑ Venereal Disease/STDs
- ❑ A.I.D.S./H.I.V.
- ❑ Hepatitis: A, B, C
- ❑ Frequent Headaches
- ❑ Artificial Joints (Hip, Knee, etc.)
- ❑ Canker Sores/Cold Sores
- ❑ Fainting/Dizzy Spells
- ❑ Epilepsy/Seizures
- ❑ Hay Fever/Sinus Trouble
- ❑ Allergies/Hives
- ❑ Shingles
- ❑ Anxiety Disorder
- ❑ Psychiatric Treatment
- ❑ Drug/Alcohol Addiction
- ❑ Emphysema/Asthma
- ❑ Depressed Immune System
- ❑ Organ Transplant
- ❑ Osteoporosis
- ❑ Other_____

Are you allergic to or have you reacted adversely to any of the following?

Please check any that apply.

❑ Aspirin ❑ Codeine ❑ Demerol ❑ Percodan ❑ Valium ❑ Sulfa ❑ Nitrous Oxide ❑ Penicillin ❑ Erythromycin ❑ Tetracycline ❑ Other Antibiotics ❑ Latex ❑ Metals/Jewelry ❑ Local Anesthetic

*List any other allergies here:*_____

IN CASE OF EMERGENCY, WHOM MAY WE CONTACT? (Outside of child's home)

Name_____**Home Phone No.**(____)_____**Work Phone No.** (____)_____

Relationship to Patient_____

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment or amount that my insurance does not cover.

Parent/Guardian Signature _____**Date**_____

Doctor Signature _____**Date**_____

Update Record

Date	Initial