OFFICE USE ONLY

Welcome To
Children's Dentistry Of Naples
Gerardo Santiago, DDS

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Tell Us About Your Child

Today's Date: ________________

Child's Name: ______________________________
Last First MI

Child's Birthday:____/____/____ Child's Age: __________

Nickname: ______________________ Male Female

School: ________________ E-mail: ______________

Child's Home Phone# ______________________________

Child's Home Address: ______________________________

____
City State Zip

General Information

Whom may we Thank for referring you? ______________

____

Other siblings seen by us: ______________________

Previous/Present Dentist ______________________
Please Circle

Last Visit Date: ______________________

Parent's Marital Status ❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

How do you think your child will react to this dental visit?

❑ very poorly ❑ poorly ❑ well ❑ excellently

Mother's Name ______________________________ SS# ______________
Last First Middle

Address ______________________________ Date of Birth ______________
If different than patient's

Telephone ______________________________
Home Work Cell E-mail Address

Employer's Name ______________ Occupation __________ Employer's Address ______________

Father's Name ______________________________ SS# ______________
Last First Middle

Address ______________________________ Date of Birth ______________
If different than patient's

Telephone ______________________________
Home Work Cell E-mail Address

Employer's Name ______________ Occupation __________ Employer's Address ______________

-- If parents are not living together, who has custody? ______________________________

Guardian's Address ______________________________ Telephone ______________

Payment to be made by: Cash ❑ Check ❑ Credit Card ❑

If you have insurance please check above for patient deductible information.

In case of emergency notify: Name other than parents ______________________________

Phone No.: ______________________________ Relationship to Patient: ______________

Primary Dental Insurance

Insurance Co. Name ______________________
Insurance Co. Address: ______________________
Insurance Co. Phone #: ______________________
Group # (Plan, Local, or Policy #): ______________
Policy Owner's Name: ______________________
Relationship to Patient: ______________________
Policy Owner's Birthdate:______________SS #:__________
Policy Owner's Employer: ______________________
Employer's Address & Zip ______________________

Secondary Dental Insurance

Insurance Co. Name ______________________
Insurance Co. Address: ______________________
Insurance Co. Phone #: ______________________
Group # (Plan, Local, or Policy #): ______________
Policy Owner's Name: ______________________
Relationship to Patient: ______________________
Policy Owner's Birthdate:______________SS #:__________
Policy Owner's Employer: ______________________
Employer's Address & Zip ______________________

Why did you bring the child to the dentist today?

____

____

Please discuss any serious medical problems that the child has had: ____________________________

____

____

Please describe the child's current physical health:
❑ Good ❑ Fair ❑ Poor

Does/did the child have any of the following habits?

- Y N Lip Sucking / Biting
- Y N Nursing / Bottle Habits
- Y N Nail Biting
- Y N Thumb / Finger Sucking

Was the child ever breast fed? ❑ Yes ❑ No
Is Child Adopted? ❑ Yes ❑ No

Please list all drugs the child is currently taking:

____

____

Please list all drugs that the child is allergic to:

____

____

Has the child ever had any of the following medical problems?

- Y N **Immunizations Current**
- Y N Abnormal Bleeding
- Y N **Allergies to any Drugs**
- Y N Anemia
- Y N Any Hospital Stays
- Y N Any Operations
- Y N Asthma
- Y N Cancer
- Y N Chicken Pox
- Y N Congenital Heart Defect
- Y N Convulsions/Epilepsy
- Y N Diabetes
- Y N Exposed to HIV, but Neg.
- Y N Handicaps/Disabilities
- Y N Hearing Impairment
- Y N Hemophilia
- Y N Hepatitis
- Y N Hives
- Y N HIV+/AIDS
- Y N Kidney/Liver Problems
- Y N Measles
- Y N Mononucleosis
- Y N Rheumatic/Scarlet Fever
- Y N Skin Rash
- Y N Tuberculosis (TB)

Y N **Heart Murmur**

If Yes, what type? ____________________________

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

____

Signature of parent or guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at time of service, unless prior arrangements have been approved.