Welcome to Newbury Park Dentistry for Children and Young Adults. We, Karen A. Sue, D.D.S., Lorraine I. Neri, D.D.S. and Carla Abboud, D.D.S., are committed to creating a positive attitude toward dentistry and oral health. Please take a few moments to fill out the following form. We look forward to working with you to maintain your child's dental health!

DATE: ______________________________

REASON FOR VISIT

_____ Examination, X-rays if necessary, cleaning & fluoride treatment
_____ Orthodontic question or problem
_____ Pain, discomfort, accident or emergency care
_____ Consultation regarding __________________________________

PATIENT

____

FIRST NAME MIDDLE LAST NAME NICKNAME

AGE _______ DATE OF BIRTH _________________ MALE ___________ FEMALE ________

HOME PHONE ________________ CELL PHONE ____________________ EMAIL __________________________

HOME ADDRESS ________________________________ CITY ________________ ZIP ______________

BY WHOM REFERRED ______________________ CHILD'S SCHOOL ________________________ GRADE _____

FIRST NAMES OF THE CHILD'S SIBLINGS ____

DENTAL HISTORY

Y N Is this your child's first visit to the dentist? If not, approximate date of child's last visit. ___________
Y N Is your child's water fluoridated?
Y N Is your child taking any fluoride supplements?
Y N Has your child ever had any jaw pain or tenderness?
Y N Does your child brush their teeth daily?
Y N Does your child floss their teeth daily?

Does your child have any of the following habits?

Y N thumb/finger sucking/pacifier (please circle)
Y N grinding/bruxism
Y N nail biting
Y N mouth breathing
Y N nursing bottle habits/ breast-feeding (please circle)

Are there any other concerns you would like to bring to our attention? ______________________________
____

MEDICAL HISTORY

Height __________________ Weight _________________
Child's Physician ________________________________
Phone # _________________ Date of last visit ____________
Please describe the child's current physical health:
Good ___________ Fair ______________ Poor ____________
Please list all medications your child is currently taking:
____
____
____

MEDICAL HISTORY (CONTINUED)

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

Y N Blood Transfusion
Y N Heart Murmur
Y N Cancer
Y N Diabetes
Y N Rheumatic Fever
Y N HIV+ / AIDS
Y N Hemophilia
Y N Asthma
Y N Hepatitis
Y N Tuberculosis (TB)
Y N Congenital Heart Defect
Y N Convulsion/Epilepsy
Y N Abnormal Bleeding
Y N Hearing Impairments
Y N Speech Impairments
Y N Any Operations
Please explain: ______________________________
Y N Any stays in a hospital
Please explain: ______________________________
Y N Kidney/Liver problems
Y N Handicaps/Disabilities/Special Needs
Please explain: ______________________________
Y N Latex Allergy
Y N Other Allergy (Details) ______________________
Y N **Allergies to any medications?**
Please list: ________________________________
____

Please describe any other medical conditions your child has: ______________________________
____
____

MOTHER'S INFORMATION

Mother's name____________________

Married_____ Single_____ Divorced_____

SS #__________ Birth date________

Address if different____________________

Phone
Home ________ Work________
Cell ________

Occupation____________________
Employer____________________
Employer's address____________________

Dental Insurance Company
Name____________________
Address____________________
Group Number____________________

FATHER'S INFORMATION

Father's Name____________________

Married_____ Single_____ Divorced_____

SS #__________ Birth date________

Address if different____________________

Phone
Home ________ Work________
Cell ________

Occupation____________________
Employer____________________
Employer's address____________________

Dental Insurance Company
Name____________________
Address____________________
Group Number____________________

Additional Dental Insurance Information Subscriber Name____________ Birth Date________

SS #________ Employer __________ Ins. Co. Name ____________

Group#________ Phone#________ Address ________________

Relationship to Patient________________

Emergency Contact: (Please list someone who does not live in household)

Name____________________ Phone# (cell/home/work – circle one)__________

Person Responsible for Account
Name ____________________

Address (if different) ____________________

Home Phone________ Work Phone ________

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 that it is my responsibility to inform this office of any changes in my child's medical status. I also authorize the office staff of Newbury Park Dentistry for Children to perform the necessary dental services my child may need, using the appropriate materials and drugs. Parents will be consulted before any treatment is started.
<u>The parent or guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved</u>.

A Late Fee of 18% per year will be added to all past due balances.
A $25 fee will be charged for each check returned by the bank.
There will be a fee charged for cancelled appointments without 24 hour notice.

Signature of Parent or Guardian ____________________ Date __________

I acknowledge that I have been informed of and have received a copy of the HIPAA guidelines and Dental Materials Fact Sheet ________ (please initial)