Victor Valley
Kids Dental

Today's Date:______________________ ***Welcome to Our Office***

PATIENT INFORMATION- 1st CHILD

Child's Name:______________________________
Nickname:________________________________
Mailing Address:___________________________
City:________________State______Zip_________
Home#_______________Cell #_________________
Child's SSN_______________________________
Birth date:____________Age____ ❑Male ❑Female
School:__________________________________

PATIENT INFORMATION- 2nd CHILD

Child's Name:______________________________
Nickname:________________________________
Birth date:____________Age____ ❑Male ❑Female
Child's SSN_______________________________
School:__________________________________

PATIENT INFORMATION - 3rd CHILD

Child's Name:____________________________________
Nickname:______________________________________
Birth date:____________Age:__________ ❑Male ❑Female
Child's SSN_____________________________________
School____

PATIENT INFORMATION - 4th CHILD

Child's Name:____________________________________
Nickname:______________________________________
Birth date:____________Age:__________ ❑Male ❑Female
Child's SSN_____________________________________
School:____

Person with child(ren) today:________________________
Do you have legal custody: ❑Yes ❑No

Relationship to Child(ren):_________________________

MOTHER'S INFORMATION

❑Mother ❑Step-Mother ❑Guardian
Name:____
Birth Date:__________________S.S.#__________________
Address (if different)___________________________Apt#___
City:______________________State_____Zip__________
Home # ______________________ Cell #________________
Email:____
DL#:____
Occupation:_______________________________________
Employer:____
Marital Status (Circle One): Single Married Divorced
Preferred Contact Method: ❑Home ❑Cell ❑Email

FATHER'S INFORMATION

❑Father ❑Step-Father ❑Guardian
Name:____
Birth Date:__________________S.S.#__________________
Address (if different)___________________________Apt#___
City:______________________State_____Zip__________
Home # ______________________ Cell #________________
Email:____
DL#:____
Occupation:_______________________________________
Employer:____
Marital Status(Circle One): Single Married Divorced
Preferred Contact Method: ❑Home ❑Cell ❑Email

INSURANCE INFORMATION

Primary Insurance:
Policy holder's name:_______________________________
Policy holder's Birth date:___________________________
Relationship to Patient:_____________________________
Insurance Company_________________________________
Employer____
Policy holder SSN or ID #:___________________________
Secondary Insurance: ____________________________

BILLING INFORMATION (If different from Parents)

Person Responsible For Account
Name:____
Relationship to Patient:______________________________
Billing Address: _____________________________
City:_______________________State______Zip_______
Employer:____
SSN:_________________________ DL#:________________
Home Phone:_____________ Work Phone:______________

May we send appointment reminders via text message? **YES or NO**

Victor Valley
Kids Dental

Child's Name:___________________________

DENTAL HISTORY

Former Dentist: Date of last exam:

Date of last x-rays:

Reason for Today's Visit: ☐ Exam ☐ Emergency ☐ Consultation

How Often Does Your Child Brush? How Often Does Your Child Floss?

Please check any of the following conditions that apply to your child:

☐ Bad Breath
☐ Bleeding Gums
☐ Clicking or Popping Jaw
☐ Food Collection Between Teeth
☐ Grinding Teeth
☐ Loose teeth or broken fillings
☐ Sensitive to Cold
☐ Sensitivity to Heat
☐ Sensitivity to Sweets
☐ Sores or growths in mouth
☐ Thumb sucking
☐ Nail Biting

MEDICAL HISTORY

Child's Physician: Date of Last Visit:

Address: Phone Number:

Is Child taking any of the following medications? ☐ Pain Killers(including Aspirin) ☐ Ritalin

☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Muscle Relaxers ☐ Other:

Has the child ever been diagnosed with or treated for any of the following conditions?

Yes☐ No☐ Heart Murmur
Yes☐ No☐ Rheumatic Fever
Yes☐ No☐ Artificial Heart Valves
Yes☐ No☐ Congenital Heart Defect
Yes☐ No☐ Scarlet Fever
Yes☐ No☐ Surgeries/Operations
Yes☐ No☐ Chemotherapy
Yes☐ No☐ Jaw Problems/TMJ
Yes☐ No☐ Hearing Problems
Yes☐ No☐ Hearing Problems
Yes☐ No☐ Heart Problems
Yes☐ No☐ Tonsillitis
Yes☐ No☐ Respiratory Problems
Yes☐ No☐ Asthma/Difficulty Breathing
Yes☐ No☐ Blood Transfusion
Yes☐ No☐ Leukemia
Yes☐ No☐ Anemia
Yes☐ No☐ Diabetes/Hypoglycemia
Yes☐ No☐ Hemophilia
Yes☐ No☐ Abnormal Bleeding
Yes☐ No☐ Cleft Lip/Palate
Yes☐ No☐ Autism/Autism Spectrum
Yes☐ No☐ Birth Defects
Yes☐ No☐ High/Low Blood Pressure
Yes☐ No☐ Hepatitis
Yes☐ No☐ Artificial bones/joints
Yes☐ No☐ Liver/kidney Organ Problems
Yes☐ No☐ HIV/AIDS/ARC
Yes☐ No☐ Tuberculosis TB
Yes☐ No☐ ADD/ADHD
Yes☐ No☐ Seizures/Epilepsy
Yes☐ No☐ Cerebral Palsy

List any operations/surgeries:____

Allergic to:
Yes☐ No☐ Latex
Yes☐ No☐ Penicillin/Amoxicillin
Yes☐ No☐ Aspirin
Yes☐ No☐ Tetracycline
Yes☐ No☐ Dental Anesthetics
Yes☐ No☐ Food Allergies
Other:_________________________

Has your child every taken Phen fen?: Yes☐ No☐

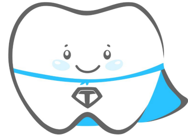
Are there any other special conditions not listed that your child has/ever had:______________________

____

I affirm that the information I gave on this form is correct to the best of my knowledge and is my responsibility to inform this office of any changes in the child's medical status. I authorize my insurance benefits to be paid directly to Victor Valley Kids Dental and I understand that I am responsible for the payment of deductibles, co-payments and any balances not covered by my insurance. I also authorize Victor Valley Kids Dental to release any information required to process the child's claims. I understand that payment is due at the time of service.

_______________________________________ ______________________________________

Dr. Signature Date Signature of Parent/Legal guardian Date



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GENERAL CONSENT FOR ACCOMPANYING CHILD TO DENTAL OFFICE FOR TREATMENT

I, ____ THE LEGAL PARENT OR GUARDIAN FOR
(Parent/Legal Guardian's Name)

____GRANT____
(Patient's Name) (Name of individual being granted authorization)

- ☐ GRANDPARENT
- ☐ AUNT/UNCLE
- ☐ SIBLING
- ☐ FRIEND
- ☐ COURT-APPOINTED CUSTODIAN
- ☐ OTHER:________________________________

THE PERMISSION TO ACCOMPANY MY CHILD TO HIS/HER DENTAL APPOINTMENT WITH VICTOR VALLEY KIDS DENTAL.

IT IS UNDERSTOOD THAT THE ABOVE NOTED ADULT ACTS ON MY BEHALF AND IS PERMITTED TO MAKE DECISSIONS REGARDING THE TREATMENT OF MY CHILD IN THE EVENT THAT I CANNOT BE REACHED.

IT IS UNDERSTOOD THAT I REMAIN FINANCIALLY RESPONSIBLE FOR THE ACCOUNT OF MY CHILD.

PARENT/LEGAL GUARDIAN SIGNATURE____

DATE_______________________

PLEASE NOTE:
THIS AUTHORIZATION WILL REMAIN ON FILE AND REMAIN ACTIVE UNTIL SUCH TIME THE CHILD IS NO LONGER A PATIENT WITH OUR OFFICE OR THE PARENT OR LEGAL GUARDIAN SENDS WRITTEN INSTRUCTION TO REMOVE THE ABOVE NAMED PERSON/PERSONS FROM RESPONSIBLITY TO ACCOMPANY CHILD.