World of Smiles
Pediatric Dentistry
Shina D. Patel, DDS
Board Certified Pediatric Dentist

FIRST VISIT REGISTRATION & HEALTH HISTORY

Your Child

Child's Name _____ Date _____
Last First Mi
Nickname _____ Gender ❑ Male ❑ Female
Date of Birth _____ Age _____ Phone _____
School _____ Grade _____ SS# _____
Child's Address _____ City _____ State _____ Zip _____
Who is accompanying child today? _____ Relationship _____
Whom may we thank for referring you to our office? _____
Name and ages of other children in family: _____
Is child adopted? ❑ Yes ❑ No If yes, does child know? ❑ Yes ❑ No

Responsible Party

Name _____ Relationship _____
Address _____ SS# _____ DL# _____
Email _____ Home Phone _____ Cell _____ Work _____
Who is Responsible for Making Appointments? _____

Parent or Guardian Information ❑ Mother ❑ Stepmother ❑ Guardian

Name _____ Address _____
Email _____ Phone-Home _____ Cell _____ Work _____
Employer _____ Occupation _____ SS# _____ DL# _____
Marital Status ❑ Single ❑Married ❑ Separated ❑ Divorced ❑ Widowed

Parent or Guardian Information ❑ Mother ❑ Stepmother ❑ Guardian

Name _____ Address _____
Email _____ Phone-Home _____ Cell _____ Work _____
Employer _____ Occupation _____ SS# _____ DL# _____
Marital Status ❑ Single ❑Married ❑ Separated ❑ Divorced ❑ Widowed

Emergency Contact Information

Name _____ Address _____
Relationship _____ Phone-Home _____ Cell _____ Work _____

Primary Insurance

Insured's Name _____ Relationship _____
Birthdate _____ SS# _____
Employer _____ Date Employed _____ Occupation _____
Insurance Co. _____ Group # _____ Employee # _____
Ins. Co. Address _____ City _____ State _____ Zip _____

Additional Insurance

Insured's Name _____ Relationship _____
Birthdate _____ SS# _____
Employer _____ Date Employed _____ Occupation _____
Insurance Co. _____ Group # _____ Employee # _____
Ins. Co. Address _____ City _____ State _____ Zip _____

858-549-7771 858-549-7774 fax 10672 Wexford Street Suite 285 San Diego, California 92131

Has your child ever had any of the following:

Yes	No		Yes	No		Yes	No	
❑	❑	Aids/HIV	❑	❑	Diabetes	❑	❑	Pneumonia
❑	❑	AttentionDeficit/Hyperactivity	❑	❑	Drug or Alcohol Abuse	❑	❑	Pregnancy
❑	❑	Anemia	❑	❑	Epilepsy	❑	❑	Psychiatric Disorder
❑	❑	Allergy/Asthma	❑	❑	Endocrine/Growth Disorders	❑	❑	Rheumatic Fever
❑	❑	Autism	❑	❑	Eye Problems	❑	❑	Scarlet Fever
❑	❑	Bleeding Abnormalities	❑	❑	Fainting/Dizziness	❑	❑	Scoliosis
❑	❑	Brain Injury	❑	❑	Hearing Loss	❑	❑	Sickle Cell Anemia
❑	❑	Bronchitis	❑	❑	Heart Disease/Murmur	❑	❑	Sinus Problems/Snoring
❑	❑	Cancer	❑	❑	Hemophilia	❑	❑	Sore Throat (frequent)
❑	❑	Cerebral Palsy	❑	❑	Hepatitis	❑	❑	Enlarged Tonsils/Adenoids
❑	❑	Chicken Pox	❑	❑	Jaundice	❑	❑	Spina Bifida
❑	❑	Cleft Lip/Palate	❑	❑	Leukemia	❑	❑	Tuberculosis
❑	❑	Communicable Disease	❑	❑	Measles			Other:
❑	❑	Convulsions/Seizures	❑	❑	Mental Retardation			❑ _____
❑	❑	Developmental Delay	❑	❑	Mumps			❑ _____

Please explain any checked items:

_____

❑ This child has never been diagnosed as having any of the above conditions.

How often does your child brush? _____ Floss? _____

Is brushing/flossing supervised? ❑ Yes ❑ No By whom? _____

Is the child's water fluoridated? ❑ Yes ❑ No ❑ Don't Know

Is your child receiving fluoride supplements? ❑ Yes ❑ No

❑ Tablets ❑ Drops Dose: _____

Is this your child's first dental visit? ❑ Yes ❑ No

Previous Dentist & City _____

Date of last visit _____ Date of last dental x-rays _____

Any injuries to your child's teeth or jaw? ❑ Yes ❑ No

When/What _____

Has your child had recent dental pain? ❑ Yes ❑ No

Explain _____

❑ Breast-feeding (till Age) ❑ Bottle (till Age)

❑ Thumb/Finger Sucking ❑ Pacifier ❑ Nail Biting

❑ Dental Grinding/Clenching ❑ Mouthbreathing/Snoring

Has your child experienced any unfavorable reaction from previous medical or dental care? ❑ Yes ❑ No Explain: _____

Child's Physician _____ Phone _____

Address _____

Date of Last Exam (list results) _____

Please list any serious medical problem, hospitalizations, surgeries the child has had _____

_____

Please list all medications the child is currently taking (Give reasons) _____

Premedication prior to dental treatment? ❑ Yes ❑ No Why? _____

Is your child under the care of a specialist for any medical reason? ❑ Yes ❑ No Why? _____

Specialists Name _____ Phone _____

Does your child have a physical or medical disability/delay? ❑ Yes ❑ No Please list _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? ❑ Yes ❑ No

(if yes, please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc)? ❑ Yes ❑ No

Is the child up to date on immunizations? ❑ Yes ❑ No

Do you wish to speak to the doctor privately about a special concern ❑ Yes ❑ No

AUTHORIZATION AND RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize Dr. Patel and staff to perform necessary dental procedures including, but not limited to, the use of nitrous oxide, local anesthetic and take any necessary radiographs to diagnose and/or treat my child's dental needs. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I also authorize Dr. Patel to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other healthcare practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf of my dependents.

Signature of Patient (or Parent/Guardian if minor) _____ Date _____