OCEAN PEDIATRIC DENTAL

Dr. Elisa Velazquez, Dr. Matthew Sones and Associates

MEDICAL HISTORY

Patient's name_____Age_____Date_____
Last First

Date of Birth_____Male_____Female_____Nickname_____Weight_____

Address_____
City State Zip

Home Phone_____Cell/Pager #_____

E-mail _____

Pediatrician_____
Name Address Phone

Other Health Care Providers_____

Whom may we thank for referring you?_____

1. General status of Health?_____Excellent_____Good_____Fair

2. Date and reason for child's last medical exam
   _____

3. Has your child ever been hospitalized or received sedation/anesthesia?
   Reason_____

4. Is your child allergic to any medicine, food or substance?
   List_____

5. Is your child taking any medications?
   List_____

6. Has your child ever had any of the following? Please Check

___Heart Murmur	___Asthma	___Chronic sinusitis	___Lung disease
___Heart Disease	___Anemia	___Cerebral Palsy	___Seizures
___Hepatitis	___Bronchitis	___Bleeding Problems	___Epilepsy
___Diabetes	___Tuberculosis	___Blood Transfusion	___Other
___HIV(+)or AIDS	___Thyroid	___Hearing Difficulty	_____
___Kidney Disease	___Hemophilia	___Liver Disease	

7. Has your child's physical development been normal?____Yes ____No
   If no, please explain:_____

8. Does your child have any Psychological/Emotional /Behavioral concerns? ____Yes ____No
   If yes, please explain:_____

9. Has your child been diagnosed with the following: ADD__ ADHD __ SPD__ AUTISM__NONE__

(Over Please)

Dental History

1. Is this your child's first visit to the dentist? ____Yes____No
2. Name, Date and Address of previous dentist_____
   _____
   Reason for the visit?_____
   Were any x-rays taken? ____Yes ____No
   Was visit pleasant? ____Yes ____No
   If no, please explain_____
   _____
3. Has your child ever had any of the following? Please check:
   ____Dental fillings ____Local anesthesia (Novocain) ____Sealants
   ____Orthodontics ____Nitrous oxide (Laughing gas) ____Extraction
   ____Injury to teeth, jaw or face ____Nerve treatment
4. Does your child have any oral habits? Please check:
   ____Pacifier ____Finger/Thumb sucking ____Breastfeeding
   ____Nail biting ____Tongue thrusting ____Bottle nursing
   ____Grinding teeth
5. Are you happy with the appearance of your child's teeth? ____Yes____No
   If no, please explain_____
6. What concerns you most about your child's teeth?_____
   _____
7. Does your child take fluoride in any form? Explain_____
8. Child's interests, hobbies, pets, etc:_____
9. Please list any questions you would like to have answered_____
   _____

PARENT/GUARDIAN INFORMATION

Parent#1 name_____ Parent #2 name_____

Occupation_____ _____

Soc. Sec. #_____ _____

Birth Date_____ _____

Employer_____ _____

Address_____ _____

Bus phone_____ _____

Cell Phone_____ _____

Dental Ins. Carrier_____ _____

Policy #_____ _____

Consent

Because _____is a minor, it is necessary that signed Permission be obtained from a parent or guardian before dental treatment is initiated. Therefore, I authorize the doctor and the dental staff to perform the necessary dental services my child may require. Furthermore, I will be responsible for any fee incurred on the above-named child for dental services rendered.

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash, check or credit card at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of $40.00 will be charged to your account if referred to our collection agency.
A service charge of $40.00 will be charged to your account for any checks(s) returned for insufficient funds.
The parent that accompanies the child for their dental visit is responsible for payment for services rendered.

I grant my permission to you or your assignee, to telephone me at home, work, or cell phone to discuss matters related to this form.

There will be a $25.00 fee (for each ½ hour of time set a side for the appointment) for any broken appointment unless 24 hour notice is given.

I have read the above conditions of treatment and payment and agree to their content.

X_____

PRINTED NAME Signature of parent or guardian Date