Evangeline Shitabata, DMD, MS.
Pediatric Dentist

For your convenience? Print this form, complete all information, and bring it with you on your first visit to our office. The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name _____
Last First MI

Nickname_____ Male Female
Child's Birthdate _____/_____/_____ Child's Age _____

Child'sHome(_____)_____
SS#_____
Child's Home Address:_____

_____
APT. / CONDO #

_____
City State Zip

2. Mother's Information

Name _____

Stepmother Guardian Birthdate _____/_____/_____

Employer _____
Work # (_____)_____ Ext. _____

Home # (_____)_____ SS # _____ DL# _____

3. Father's Information

Name _____

Stepfather Guardian Birthdate _____/_____/_____

Employer _____
Work # (_____)_____ Ext. _____

Home # (_____)_____
SS # _____ DL# _____
Marital Status
Single Married Separated
Widowed Divorced

4. Who is Accompanying the Child Today?

Name _____

Relationship_____
Do you have legal custody of this child? Yes No

5. Person Responsible for Account

Name_____
Relationship_____
Billing Address _____

_____
City State Zip
Home # (_____)_____
Work # (_____)_____
E-mail _____

6. 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 _____/ _____/ _____
Social Security # _____
Policy Owner's Employer _____

7. 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 _____/ _____/ _____
Social Security # _____
Policy Owner's Employer _____

8. Dental History

Is this your child's first visit to the dentist? _____
If not, how long since the last visit to the dentist? _____
Were any x-rays taken at previous dental visits? _____
Have there been any injuries to the teeth, face or mouth?

_____

_____
If yes, please explain
_____

_____
_____
Why did you bring the child to the dentist today? _____
_____

_____
Does the child have any of the following habits?

Y N Lip Sucking / Biting Y N Nail Biting

Y N Nursing Bottle Habits Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain _____
_____
Is the child's water fluoridated?
Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in his/her jaw/ joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

9. Health History

Has the child ever had any of the following problems?

Y N	Abnormal Bleeding	Y N	Handicaps/Disabilities
Y N	**Allergies to any Drugs**	Y N	Hearing Impairment
Y N	Any Hospital Stays	Y N	Heart Murmur
Y N	Any Operations	Y N	Hemophilia
Y N	Asthma	Y N	Hepatitis
Y N	Cancer	Y N	HIV + / AIDS
Y N	**Congenital Heart Disease**	Y N	Kidney/Liver Problems
Y N	**Convulsions/Epilepsy**	Y N	Rheumatic/Scarlet Fever
Y N	Pregnancy	Y N	Allergies to Latex Product

Please discuss any serious medical problems the child has had
_____
_____
Please list all drugs the child is currently taking
_____

_____
Please list all drugs the child is allergic to _____

_____
Child's Physician _____
Phone (_____)_____
Is the child currently under the care of a physician?
Yes No

Please describe the child's current physical health...

Good **Fair** **Poor**

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

Who may we thank for referring you to us? _____
_____

10.

I understand that the information 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.
I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____
Signature of Parent or Guardian Date Relationship to Patient

For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials _____ Date _____

Insurance Verification: Effective Date _____/_____/_____

Preventive _____% Deductible $_____

Basic _____% Maximum $_____

Major _____% Electronic Claims **Yes** **No**

Doctor's Comments _____
_____
_____
_____
Does insurance cover sealants (1351)?

Yes **No**

If yes, what do they fall under? _____