



**OCEAN VIEW DENTAL CARE**  
 905 Calle Amanecer, Suite 265  
 San Clemente, CA 92673  
 (949) 388-0780 OceanViewDentist.com  
*General & Cosmetic Dentistry*

# Child's Registration & Health History

Patient Name: _____	Birthdate: _____	Home Phone: _____
Home Address: _____	City: _____	State: _____ Zip: _____
Father: _____	Birthdate: _____	Cell Phone: _____
Employer: _____	City: _____	Social Security Number: _____
Mother: _____	Birthdate: _____	Cell Phone: _____
Employer: _____	City: _____	Social Security Number: _____

Person Responsible for this Account: \_\_\_\_\_ Relation to Patient: \_\_\_\_\_ Dental Insurance?  Yes  No

**Who may we thank for referring you to our office?** \_\_\_\_\_

## Child's Medical History

Child's Physician's Name: \_\_\_\_\_ City: \_\_\_\_\_ Phone: \_\_\_\_\_

**Have you had or currently have any of the following conditions?**

Yes	No	Yes	No	Yes	No	Yes	No
Heart Disease	<input type="checkbox"/> <input type="checkbox"/>	Allergy to Local Anesthetic	<input type="checkbox"/> <input type="checkbox"/>	Hepatitis	<input type="checkbox"/> <input type="checkbox"/>	Frequent Cold Sores	<input type="checkbox"/> <input type="checkbox"/>
Heart Murmur	<input type="checkbox"/> <input type="checkbox"/>	Allergy to Any Medicine	<input type="checkbox"/> <input type="checkbox"/>	Liver Disease	<input type="checkbox"/> <input type="checkbox"/>	Radiation Therapy	<input type="checkbox"/> <input type="checkbox"/>
Mitral Valve Prolapse	<input type="checkbox"/> <input type="checkbox"/>	Please list: _____		Epilepsy	<input type="checkbox"/> <input type="checkbox"/>	Chemotherapy	<input type="checkbox"/> <input type="checkbox"/>
Rheumatic Fever	<input type="checkbox"/> <input type="checkbox"/>	Visual Disability	<input type="checkbox"/> <input type="checkbox"/>	Fainting or Dizzy Spells	<input type="checkbox"/> <input type="checkbox"/>	Psychiatric Care	<input type="checkbox"/> <input type="checkbox"/>
Artificial Heart Valve	<input type="checkbox"/> <input type="checkbox"/>	Hearing Disability	<input type="checkbox"/> <input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/> <input type="checkbox"/>	AIDS or HIV Positive	<input type="checkbox"/> <input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/> <input type="checkbox"/>	Brain Injury	<input type="checkbox"/> <input type="checkbox"/>	Artificial Joints (Hip, Knee)	<input type="checkbox"/> <input type="checkbox"/>	Asthma	<input type="checkbox"/> <input type="checkbox"/>
Heart Surgery	<input type="checkbox"/> <input type="checkbox"/>	Diabetes	<input type="checkbox"/> <input type="checkbox"/>	Kidney Trouble	<input type="checkbox"/> <input type="checkbox"/>	Immune System Disorders	<input type="checkbox"/> <input type="checkbox"/>
Premature Birth	<input type="checkbox"/> <input type="checkbox"/>	Tuberculosis	<input type="checkbox"/> <input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/> <input type="checkbox"/>	Recurring Sinus Problems	<input type="checkbox"/> <input type="checkbox"/>

Does your child have any disease, problem, or condition not listed?  Yes  No If Yes, what? \_\_\_\_\_

Has your child been under the care of a Physician during the last 2 years?  Yes  No

Is your child currently under the care of a Physician?  Yes  No If Yes, why? \_\_\_\_\_

Has your child ever been hospitalized?  Yes  No If Yes, why? \_\_\_\_\_

Is your child currently taking any medication, drugs, or pills?  Yes  No If Yes, what? \_\_\_\_\_

The medication is for what purpose? \_\_\_\_\_

Nearest Relative not living with you: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

**ABOVE INFORMATION IS TRUE:** To the best of my knowledge, all the preceding answers are true and correct. If I have any change in my health or medication, I will inform the Doctor at the next appointment. If deemed advisable, I grant permission for my Physician to be contracted for details and advice.

Patient or Guardian) Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Dental Information

What prompted you to seek dental care at this time for your child? _____  When was your child's last visit to a dentist? _____  What was done at their last visit? _____ _____  Why are you changing dentists? _____  Has the fear of discomfort kept your child from regular dental visits? <input type="checkbox"/> Yes <input type="checkbox"/> No  Has your lost any teeth prematurely? <input type="checkbox"/> Yes <input type="checkbox"/> No  Are any of your child's teeth sensitive to: <input type="checkbox"/> Heat <input type="checkbox"/> Cold <input type="checkbox"/> Biting Pressure  Has your child had braces or any orthodontic treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are you concerned about the appearance of your child's teeth for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No  Does your child brush their own teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No  How often does your child brush their teeth? _____  Does your child use dental floss? <input type="checkbox"/> Yes <input type="checkbox"/> No  Does your child's gums bleed when brushing or flossing? <input type="checkbox"/> Yes <input type="checkbox"/> No  Have you been told your child has Periodontal/Gum Disease? <input type="checkbox"/> Yes <input type="checkbox"/> No  Are you aware of any swelling or lump in your child's mouth? <input type="checkbox"/> Yes <input type="checkbox"/> No  Does your child grind or clench their teeth? <input type="checkbox"/> Yes <input type="checkbox"/> No  Are you aware of their jaw clicking or making grating-like noises? <input type="checkbox"/> Yes <input type="checkbox"/> No  Has your child ever had TMJ treatments? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**CONSENT:** The undersigned hereby authorizes the Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of dental needs. I also authorize Doctor to perform all recommended treatment agreed by me and to use the appropriate medication and therapy indicated for such treatment. I understand that using anesthetic agents embodies a certain risk including, but not limited to paresthesia and allergic reactions. I understand that responsibility for payment for dental services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payment is not received by the agreed upon dates, I understand that a monthly 1.5% finance charge (18% APR) or \$4 rebilling fee, whichever is greater, may be added to my account. In the case of default of payment, I will additionally pay any collection costs and reasonable attorney fees incurred to effect collection on this account.

Patient (or Guardian) Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Dental Insurance

**IF YOU HAVE DENTAL INSURANCE:** Please complete the following thoroughly. We can input the information into our computer and bill your insurance carrier automatically. This service is FREE to you. A completed and signed insurance form **MUST** be provided on each visit unless otherwise informed by this office. As an additional courtesy, our office will accept assignment of benefits if you sign the release below.

Primary Insurance	Secondary Insurance
Insured's Name: _____ Birthdate: _____ Social Security Number: _____ Insurance ID Number: _____ Insurance Company: _____ Group/Local Number: _____ Phone: _____ Effective Date: _____ Relation to Patient: _____ Insured's Employer: _____ City: _____ Time with Company: _____	Insured's Name: _____ Birthdate: _____ Social Security Number: _____ Insurance ID Number: _____ Insurance Company: _____ Group/Local Number: _____ Phone: _____ Effective Date: _____ Relation to Patient: _____ Insured's Employer: _____ City: _____ Time with Company: _____

**ASSIGNMENT OF INSURANCE BENEFITS:** I hereby authorize and request my Insurance Company to pay directly to the Doctor the amount due on my claim for services rendered to me or my dependent. I understand that any amounts paid to this office are ESTIMATES only and I will not know the exact amount owed until my insurance has paid. I further agree that should the amount paid by my insurance be insufficient to cover the entire dental expense, I will be responsible for payment of the difference.

Patient (or Guardian) Signature: \_\_\_\_\_ Date: \_\_\_\_\_