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	❑	❑	Allergy to Local Anesthetic	❑	❑	Hepatitis	❑	❑	Frequent Cold Sores	❑	❑
Heart Murmur	❑	❑	Allergy to Any Medicine	❑	❑	Liver Disease	❑	❑	Radiation Therapy	❑	❑
Mitral Valve Prolapse	❑	❑	Please list: _____			Epilepsy	❑	❑	Chemotherapy	❑	❑
Rheumatic Fever	❑	❑	Visual Disability	❑	❑	Fainting or Dizzy Spells	❑	❑	Psychiatric Care	❑	❑
Artificial Heart Valve	❑	❑	Hearing Disability	❑	❑	Bleeding Disorder	❑	❑	AIDS or HIV Positive	❑	❑
High Blood Pressure	❑	❑	Brain Injury	❑	❑	Artificial Joints (Hip, Knee)	❑	❑	Asthma	❑	❑
Heart Surgery	❑	❑	Diabetes	❑	❑	Kidney Trouble	❑	❑	Immune System Disorders	❑	❑
Premature Birth	❑	❑	Tuberculosis	❑	❑	Thyroid Disease	❑	❑	Recurring Sinus Problems	❑	❑

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? ❑ Yes ❑ No

Has your lost any teeth prematurely? ❑ Yes ❑ No

Are any of your child's teeth sensitive to: ❑ Heat ❑ Cold ❑ Biting Pressure

Has your child had braces or any orthodontic treatment? ❑ Yes ❑ No

Are you concerned about the appearance of your child's teeth for any reason? ❑ Yes ❑ No

Does your child brush their own teeth? ❑ Yes ❑ No

How often does your child brush their teeth? _____

Does your child use dental floss? ❑ Yes ❑ No

Does your child's gums bleed when brushing or flossing? ❑ Yes ❑ No

Have you been told your child has Periodontal/Gum Disease? ❑ Yes ❑ No

Are you aware of any swelling or lump in your child's mouth? ❑ Yes ❑ No

Does your child grind or clench their teeth? ❑ Yes ❑ No

Are you aware of their jaw clicking or making grating-like noises? ❑Yes ❑No

Has your child ever had TMJ treatments? ❑ Yes ❑ No

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