Healthy Smiles
Kids Dentistry • Arpana Parti, DDS

ABOUT YOUR CHILD

CHILD'S NAME _____ DATE OF BIRTH _____

AGE _____ SEX _____ Soc. Sec _____

ADDRESS _____ APT. # _____

CITY _____ STATE _____ ZIP CODE _____

HOME PHONE _____ SECONDARY PHONE _____

EMAIL ADDRESS _____

WHAT IS THE PRIMARY CONCERN FOR TODAY'S VISIT?

Who is accompanying the child today?

Name _____

Relationship _____

Y N Do you have legal custody of the child?

2 EMERGENCY CONTACTS

Name _____

Phone Number _____

Relationship _____

Name _____

Phone Number _____

Relationship _____

PEDIATRIC CONSENT

By initialing below,
I authorize Healthy Smiles to perform the following treatment on my child (today and in the future).

Exam/ Prophylaxis
(Preventative Polishing/Cleaning)
Fluoride Treatment X-Rays,

Initials_____

PERSON RESPONSIBLE FOR ACCOUNT

NAME _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

PHONE _____ CELL PHONE _____

EMPLOYER _____

PRIMARY DENTAL INSURANCE

NAME _____

ADDRESS _____

PHONE _____

GROUP # (plan, Local, Or Policy #) _____

POLICY OWNER'S NAME _____

RELATIONSHIP TO PATIENT _____

POLICY OWNER'S DATE OF BIRTH _____

SOCIAL SECURITY # _____

POLICY OWNER'S EMPLOYER _____

SECONDARY DENTAL INSURANCE

NAME _____

ADDRESS _____

PHONE _____

GROUP # (plan, Local, Or Policy #) _____

POLICY OWNER'S NAME _____

RELATIONSHIP TO PATIENT _____

POLICY OWNER'S DATE OF BIRTH _____

SOCIAL SECURITY # _____

POLICY OWNER'S EMPLOYER _____

CONSENT TO FINANCIAL RESPONSIBILITY

Insurance coverage is only an estimate. Guarantor is Responsible for all treatment not covered by the insurance. Any questions feel free to call 661-377-2000

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Although dental personnel primarily treat the area in and around your child's mouth, their mouth is a part of their entire body. Health problems that they may have, or medication that they may be taking, could have an important interrelationship with their dentistry. Thank you for answering the following questions about your child.

Has your child ever been hospitalized or treated for any particular trauma	❍ Yes ❍ No	If yes_____
Has your child ever had a serious head or neck injury?	❍ Yes ❍ No	If yes_____
Is your child taking any medications, pills, or drugs?	❍ Yes ❍ No	If yes_____
Is this your child's first visit to the Dentist? If no, when was the last visit and what was done for your child?	❍ Yes ❍ No	If yes_____
Do you expect your child to be cooperative? If no, Please explain.	❍ Yes ❍ No	If yes_____

Are you allergic to any of the following?

☐ Asprin	☐ Penicillin	☐ Codeine	☐ Latex
☐ Sulfa Drugs	☐ Local Anesthetics	☐ Other	

Please indicate if your child has had the following:

Hemophilia	❍ Yes ❍ No	Anemia	❍ Yes ❍ No
Asthma	❍ Yes ❍ No	Frequent Cough	❍ Yes ❍ No
Tonsillitis	❍ Yes ❍ No	Heart Murmur	❍ Yes ❍ No
Heart Trouble/Disease	❍ Yes ❍ No	ADD/ADHD	❍ Yes ❍ No
Diabetes	❍ Yes ❍ No	Epilepsy or Seizures	❍ Yes ❍ No
Fainting Spells/Dizziness	❍ Yes ❍ No	Breathing Problems	❍ Yes ❍ No
Tuberculosis	❍ Yes ❍ No	Pain in Jaw Joints	❍ Yes ❍ No
Psychiatric Care	❍ Yes ❍ No	Autism	❍ Yes ❍ No

Has your child had any illness not listed above? ❍Yes ❍No If Yes_____

About your child:

Is your child currently?

Nursing	❍Yes ❍No
Thumb Sucking	❍Yes ❍No
Pacifier	❍Yes ❍No
Bottle	❍Yes ❍No
Sippy Cup	❍Yes ❍No