LAMORINDA TOOTH BUDS
pediatric dentistry
3501 School Street • Lafayette, CA 94549
925-385-8051 www.lamorindatoothbuds.com

Date:____/____/____

Patient Information

Patient's Full Name _____ Sex: (M) (F) Age _____

Nickname (if any) _____ Birthdate: ____/____/____

Whom may we thank for referring you? _____

General Information

Parent/Legal Guardian (Full Name) _____ Birthdate: ____/____/____

Relationship to Child _____ SSN: _____-_____-_____

Home Address _____

Home Phone _____ Cell Phone _____

Email _____

Employer _____ Job Title _____

Work Address _____ Work Phone _____

Is it okay to contact this parent via: Home Work Cell Email

Parent/Legal Guardian (Full Name) _____ Birthdate: ____/____/____

Relationship to Child _____ SSN: _____-_____-_____

Home Address _____

Home Phone _____ Cell Phone _____

Email _____

Employer _____ Job Title _____

Work Address _____ Work Phone _____

Is it okay to contact this parent via: Home Work Cell Email

Parent(s) are: Married Divorced Single Widowed Partners

Child Lives with: _____

Who is responsible for the account? _____

Social History

Does your child have any special hobbies or interests? _____

Names/Ages of Brother(s)/Sister(s) _____

Is your child adopted? (Y) (N)

Name of Child's School _____

Health History

Child's Pediatrician _____ Phone # _____

Has your child ever had any of the following?

ADHD/ADD	(Y)	(N)	Eating Disorder	(Y)	(N)
Allergies (if Yes, see below)	(Y)	(N)	Eczema/Skin Problems	(Y)	(N)
Anemia	(Y)	(N)	Emotional/Psychological Difficulties	(Y)	(N)
Asthma/Respiratory System/Pneumonia	(Y)	(N)	Epilepsy/Seizures	(Y)	(N)
Autism	(Y)	(N)	Fainting/Dizziness	(Y)	(N)
Bladder Problems	(Y)	(N)	Glaucoma/Eye Problems	(Y)	(N)
High/Low Blood Pressure	(Y)	(N)	Hearing Impairment	(Y)	(N)
Bone Disorder/Joint Problems	(Y)	(N)	Heart Murmur/Heart Disease	(Y)	(N)
Brain Injury	(Y)	(N)	Hemophilia/Blood Disorders	(Y)	(N)
Bruising	(Y)	(N)	Hepatitis	(Y)	(N)
Cancer/Malignancy	(Y)	(N)	HIV/AIDS	(Y)	(N)
Canker Sores/Cold Sores	(Y)	(N)	Kidney Problems	(Y)	(N)
Cerebral Palsy	(Y)	(N)	Learning Problems	(Y)	(N)
Chemo/Radiation Therapy	(Y)	(N)	Liver Problems	(Y)	(N)
Cystic Fibrosis/Lung Problems	(Y)	(N)	Premature Birth	(Y)	(N)
Diabetes	(Y)	(N)	Rheumatic Fever	(Y)	(N)
Down Syndrome	(Y)	(N)	Tuberculosis	(Y)	(N)
Earaches/Chronic Infections	(Y)	(N)	Other	(Y)	(N)

If you answered YES to any of the questions above, please explain _____

Does your child have ALLERGIES to any of the following? (Please check all that apply)

___ Medications ___ Latex/Rubber ___ Anesthetic ___ Pollen/Dust ___ Foods

___ Animals (Dogs) ___ Acrylics ___ Dyes/Coloring ___ Seasonal ___ Other

Has your child had any unfavorable reactions to drugs, anesthetics, or antibiotics? (Y) (N)

If YES, please list _____

Is your child currently taking any MEDICATIONS? (Y) (N)

If YES, please list _____

Has your child ever been HOSPITALIZED? (Y) (N)

If YES, please specify reason _____

Has your child ever had any SURGERIES? (Y) (N)

If YES, please specify _____

Does your child take any vitamin supplements? (Y) (N) ___Gummies ___ Chewables ___Drops ___Other

Are your child's immunizations up to date? (Y) (N)

Dental History

What is the primary reason for today's visit? _____

Is this your child's first dental visit? (Y) (N)

If NO, Name of Previous Dentist _____ Phone # _____

Date of Last Visit _____ How was his/her experience? _____

Were Radiographs (X-rays) taken? (Y) (N)

Has your child had any injuries to their teeth, mouth, or head? (Y) (N)

If YES, please describe _____

How often does your child brush his/her teeth per day? _____ Do you help? (Y) (N)

What type of toothpaste does your child use? ____ Fluoridated ____ Non-fluoridated ____ No toothpaste

How often does your child floss? _____ Do you help? (Y) (N)

Is your child taking any supplemental fluoride? (Y) (N) (Please Specify) _____

Does your child currently have any of the following habits? (Please check all that apply)

___ Thumb/Finger sucking ___ Pacifier ___ Teeth Grinding ___ Bottle-Feeding

___ Snoring ___ Mouth Breathing ___ Nail Biting ___ Lip Sucking ___ Other

Does your child currently use a bottle? (Y) (N) If YES, how many times per day? _____

Is the bottle used at night? (Y) (N) What do you put in the bottle? _____

Does your child currently nurse? (Y) (N)

Has either parent or the child ever been treated with Orthodontics before? (Y) (N)

How can we make this a positive experience for your child today? _____

I understand that the information I have given is correct to the best of my knowledge and it is my responsibility to inform the office of any changes in my child's health status. I authorize the dental staff to perform any necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of the treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners.

Parent/Guardian Signature: _____ **Date:** ____/____/____

Doctor's Signature: _____ **Date:** ____/____/____

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Insurance Information

Primary Insurance Company _____ Phone # _____

Policy Owner's Name _____ Relationship to Child _____

Birthdate: ____/____/____ SSN: _____-_____-_____ Group # _____

Secondary Insurance Company _____ Phone # _____

Policy Owner's Name _____ Relationship to Child _____

Birthdate: ____/____/____ SSN: _____-_____-_____ Group # _____

As a courtesy to our patients, we will file your insurance claim with the insurance company listed above for any services your child receives. However, in the event the insurance company does not pay, for any reason, the balance will become your responsibility, and will be billed directly to you. This contract is with Lamorinda Tooth Buds and yourself, and you understand that you are responsible for all charges on the account.

By signing this form I am accepting all responsibility for full payment of services rendered regardless of insurance coverage. I further understand that all payments are due and payable on the day services are rendered.

Signature of Responsible Party: _____ **Date:** ____/____/____