1507 West Yosemite Avenue • Manteca, CA 95337

(209) 823-9341•valleyoakdentalgroup.com

Welcome

Pediatric Patient Registration Form

Date: ______________________________
Child's Name: ____
Sex: O M O F Age: ________________ Birthday: ____
Who may we call to confirm your child's dental appointment by your home phone?
Name: ____ Best time to call: ____
Home address: ____ City: ____________________ State ___________ Zip _______
Can we call you at work if can't confirm your child's dental appointment by your home phone? O Yes O No O Father O Mother
Work phone ___________________________ Home phone ___________________________ Cell phone ______________________
School attending: ____ Grade ______________________________
What does your child like to talk about – sports, school, movies, music, etc. Please be specific: ______________________________
____
Do mother and father live together? O Yes O No
Names and ages of brothers and sisters:
Name: ____ Age: __________________
Name: ____ Age: __________________
Name: ____ Age: __________________
Name: ____ Age: __________________

B Employment Information:

Father's name ____
Occupation ____
Employer ____
Work Address ____
____
Work phone ____
Years _______ Month ___________ D.O.B. _________________
Social Security #: ____

Mother's Name ____
Occupation ____
Employer ____
Work Address ____
____
Work phone ____
Years _______ Month ___________ D.O.B. __________________
Social Security #: ____

C **Person Financially Responsible for Account**

YOUR name: ____
Address: ____ City: ____________________________ State: __________ Zip:__________
Phone: Day ____ Evening ____

DIVORCED PARENTS

1. NOTE: IF YOU ARE DIVORCED, THE PARENT THAT BRINGS THE CHILD INTO OUR OFFICE FOR DENTAL TREATMENT IS THE PERSON RESPONSIBLE FOR ALL CHARGES REGARDLESS OF YOUR DIVORCE DECREE.

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2. NOTE: IF YOU ARE NOT THE SAME PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT, PLEASE PRINT YOUR NAME HERE:
____ SIGN HERE ____

D **IF YOU DON'T HAVE DENTAL INSURANCE GO TO SECTION E**

Primary Insurance Coverage

**Please specify the relationship of the insured to the child*
O Father O Mother O Step-father O Step-mother O Other ____
Dental Insurance Company Name: ____
Insurance Address: ____
Group ______________________________ Policy # ________________________ Local # _________________________________
Who is child's legal guardian if other than above? ____

IF SECOND INSURANCE PLEASE COMPLETE THE FOLLOWING:

O Father O Mother O Step-father O Step-mother O Other ____
Dental Insurance Company Name: ____
Insurance Address: ____
Group ______________________________ Policy # ________________________ Local # _________________________________

E Who may we contact "OUTSIDE" of your home in case of an emergency? Must be a friend or relative other than parent living at your address:

Name ____ O Relative O Friend

Address: ____

Phone: Day _______________________________________ Evening ____

PERMISSION FOR DENTAL TREATMENT

I hereby give permission to VALLEY OAK DENTAL GROUP to render all necessary dental services and to use such methods and agents that are necessary for the child named on this form. I understand that no treatment will be started until the recommended treatment, time involved and the financial investment and arrangements have been discussed with me by the dentist or a staff member, at which time I may void this permission if I so choose. Furthermore, I will be responsible for any charges incurred by this child for dental treatment.

Date: _____________________________ Signature ____

DENTAL INFORMATION

1. Is this an emergency visit? O Yes O No
2. Is this the first visit to the dentist? O Yes O No
3. Is your child apprehensive about this dental visit? O Yes O No
4. Would you describe your child as: O Shy O Frightened O Apprehensive O Eager O Aggressive
5. Has your child had any unfavorable dental or medical visits? O Yes O No
6. How would you expect your child to behave in our office? Describe: ____
7. Is there anything that you are particularly concerned about in regards to your child's dental health? O Yes O No
   If yes, explain: ____
8. Does your child have any of the following habits:
   O Thumb/Finger Sucking O Mouth Breathing O Nail/Lip Biting O Grind Teeth at Night O Tongue Thrust
9. Has your child been seen by an orthodontist? O Yes O No
10. Does your child brush daily? O Yes O No
11. Is dental floss used? O Yes O No
12. Is fluoride taken? O Yes O No If YES, mark how: O Drops O Tablets O Vitamins
13. Have mother and father had a lot of tooth decay? O Yes O No
14. Do you feel your child's primary teeth are important to keep decay-free to prevent premature loss? O Yes O No
15. Have you heard of sealants that are applied to the tops of primary and permanent molars to prevent tooth decay? O Yes O No
16. Has either parent had difficulty getting numb? O Yes O No
17. Have there been any injuries to your child's teeth (falls, blows, chips, etc.)? O Yes O No If yes, explain:
    ____

PLEASE ANSWER THESE DENTAL QUESTIONS FOR A YOUNGER CHILD IF APPROPRIATE:

1. Do you assist your child in brushing his or her teeth? O Yes O No
2. At what age did your child stop using a nursing bottle? _____________________
3. When did your child's first tooth erupt? ________________ months old
4. Would you be interested in having a consultation with a registered dietician in regards to nutrition and dental health for your child or family if recommended by your dentist? O Yes O No

PLEASE ANSWER THESE DENTAL QUESTIONS FOR AN OLDER CHILD IF APPROPRIATE:

1. Does your child chew gum regularly? O Yes O No
2. Does your child eat more junk food than they should? O Yes O No
3. Are there any other habits you want us to be aware of? O Yes O No Please explain: _________________________
4. Would you be interested in having a consultation with a registered dietician in regards to nutrition and dental health if recommended by your dentist? O Yes O No

Who may we thank for referring you to VALLEY OAK DENTAL GROUP? We want to thank them because we are always accepting new patients and we welcome all referrals. Name ____

AUTHORIZATION TO PAY BENEFITS

I hereby authorize payment directly to the undersigned, VALLEY OAK DENTAL GROUP, for dental benefits, otherwise made payable to me for dental services provided. I understand that I am financially responsible for all charges not covered by this authorization.

_____________________ ____

DATE SIGNATURE OF PERSON RESPONSIBLE FOR ACCOUNT