VALLEY OAK
DENTAL GROUP
1507 West Yosemite Avenue
Manteca, California 95337
(209) 823-9341

WELCOME

Pediatric Patient Registration Form

Please fill out both sides of this form — we will be happy to assist you if you need help.

Date: _____

Child's Name: _____
FIRST MIDDLE INITIAL LAST NICKNAME

Sex: ☐ M ☐ F Age: _____ Birthdate: _____

Who may we call to confirm your child's dental appointment? Name: _____ Best time to call: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Can we call you at work if we can't confirm your child's dental appointment by your home phone? ☐ Yes ☐ No ☐ Father ☐ Mother

Work phone: (_____) _____ Cell phone: (_____) _____ Best time to call: _____

School attending: _____ Grade: _____

What does your child like to talk about — School, sports, movies, music, etc. Please be specific: _____

_____

_____

Do mother and father live together? ☐ Yes ☐ 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: _____ Months: _____ D.O.B. _____

Social Security #: _____

Mother's Name: _____

Occupation: _____

Employer: _____

Work Address: _____

_____

Work phone: (_____) _____

Years: _____ Months: _____ 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.

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

_____ SIGN HERE _____

D **IF YOU DO NOT HAVE DENTAL INSURANCE GO TO SECTION E**

Primary Insurance Coverage

* *Please specify the relationship of the insured to the child.*

☐ Father ☐ Mother ☐ Step-Father ☐ Step-Mother ☐ Other: _____

Dental Insurance Company Name: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Group #: _____ Policy #: _____ Local #: _____

Who is child's legal guardian if other than above? _____

IF SECOND INSURANCE PLEASE COMPLETE THE FOLLOWING:

☐ Father ☐ Mother ☐ Step-Father ☐ Step-Mother ☐ Other: _____

Dental Insurance Company Name: _____

Insurance Address: _____ City: _____ State: _____ Zip: _____

Group #: _____ Policy #: _____ Local #: _____

PLEASE FILL OUT OTHER SIDE

Creative Printing 209-946-0972

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: _____ ☐ Relative ☐ Friend

Address: _____ City: _____ State: _____ Zip: _____

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: _____, _____ Signed: _____

DENTAL INFORMATION

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

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

1. Do you assist your child in brushing his or her teeth? ☐ YES ☐ 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 dietitian in regards to nutrition and dental health for your child or family if recommended by your dentist? ☐ YES ☐ NO

PLEASE ANSWER THESE DENTAL QUESTIONS FOR AN OLDER CHILD IF APPROPRIATE

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