# Patient Information

Sunshine
PEDIATRIC DENTISTRY

Child's Name_____
*Last Name* *First Name* *Middle Initial*
□ Male
□ Female Age____ Birthday__/___/___ Nickname_____ Hobbies_____

Child's Name_____
*Last Name* *First Name* *Middle Initial*
□ Male
□ Female Age____ Birthday__/___/___ Nickname_____ Hobbies_____

Child's Name_____
*Last Name* *First Name* *Middle Initial*
□ Male
□ Female Age____ Birthday__/___/___ Nickname_____ Hobbies_____

Home Address_____
*Street* *Apt #* *City* *State* *Zip Code*
Mailing Address_____
*Street* *Apt #* *City* *State* *Zip Code*
Home Phone #_____ Mom Cell#_____Dad Cell#_____
How did you hear about us?_____
Email Address:_____
*We remind you about appointments via email, text message and phone calls.*

## PARENT'S INFORMATION

Circle One:
Father Stepfather Guardian
Name_____
Date of Birth:___/___/____
Address (if different from patient)
_____
Home Phone_____
*(if different from above)*
Work Phone_____
*(if different from above)*
Employer_____
Do you have dental insurance coverage for minor/child? YES NO

Circle One:
Mother Stepmother Guardian
Name_____
Date of Birth:____/____/____
Address (if different from patient)
_____
Home Phone_____
*(if different from above)*
Work Phone_____
*(if different from above)*
Employer_____
Do you have dental insurance coverage for a a minor/child? YES NO

**PRIMARY INSURANCE**

Subscriber Name:_____
Subscriber SSN#:_____
Subscriber Date of Birth:___/___/_____
Insurance Co._____
Group #_____
Policy/I.D. #_____

**SECONDARY INSURANCE**

Subscriber Name:_____
Subscriber SSN#:_____
Subscriber Date of Birth:_____/___/_____
Insurance Co. _____
Group #_____
Policy/I.D. #_____

## EMERGENCY CONTACT

In the event of an emergency, whom should we contact?_____
Name_____Relationship_____Phone#_____
Name_____Relationship_____Phone#_____

## PHOTO CONSENT

I _____, give consent for Sunshine Pediatric Dentistry to capture a photographic imagery of my child _____, for their records only. I understand that for Sunshine Pediatric Dentistry staff will have access to their photo in the dental record.

**Patient/Guardian Signature**_____ **Date**_____

## SOCIAL MEDIA CONSENT

I _____, give consent for Sunshine Pediatric Dentistry to post imagery of my child/children, for social media. I understand that for Sunshine Pediatric Dentistry staff will utilize the image for social media purposes only.

**Patient/Guardian Signature**_____ **Date**_____

## CONSENT FOR TREATMENT

The information that I have given is correct and complete to the best of my knowledge. It will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I am the legal guardian of the patient.

I authorize Associate Dentist/Staff to perform the necessary dental procedures: complete dental examination (check-up), prophylaxis (cleaning), fluoride treatment, radiographs (x-rays), sealants, study models, and other diagnostic/preventive aids deemed necessary by the Dentist and the staff to make a thorough diagnosis of my child's dental needs.

I authorize the Dentist and Staff to provide any information to other Doctors (physicians, dentist, etc.) for the purpose of consultation. I understand that prior to providing any treatment I will be advised about such treatment, that I may ask questions concerning the treatment, and that I may revoke this BEFORE treatment is provided. As the parent/legal guardian of the patient, I do hereby grant the dentist and the staff permission to perform any needed treatment(s).

**Patient/Guardian Signature**_____ **Date**_____

## APPOINTMENT AUTHORIZATIONS

For future appointments, if you are planning to send your child with someone other than a parent/legal guardian, please provide the following information (must be 18yrs or older): Name of authorized person(s) to accompany my child for future treatment visits:

1. **NAME:**_____**Relationship to Child:**_____
2. **NAME:**_____**Relationship to Child:**_____

# FINANCIAL AGREEMENT

- **Your insurance is a contract between you, your employer, and the insurance company; our relationship is with you, NOT the insurance company. We file your insurance claim as a courtesy to you.**
- ALL charges incurred are charged directly to YOU and you are personally responsible for payment. Deductibles and co-payments are due at the time of treatment. We ESTIMATE your co-payments according to your policy. We DO NOT in any way guarantee that your insurance will pay this amount.
- **If the insurance company doesn't pay within a 60 days, it is required that you pay the balance due.**
- I hereby authorize payment directly to for Sunshine Pediatric Dentistry, the insurance benefits otherwise payable to me, and authorize release of any information required to process insurance claims.

**Patient/Guardian Signature**_____ **Date**_____

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I, _____ have reviewed a copy of for Sunshine Pediatric Dentistry
(Parent or Legal Guardian's Name) Notice of Privacy Practices regarding my children.

**Patient/Guardian Signature**_____ **Date**_____
OFFICE USE ONLY: ___Patient Refused to Sign ___Emergency Situation ___Language Barrier ___Other

# Appointment Policy

We reserve time in our schedule especially for your child, and in consideration of others we request at least **48 hours notice prior to cancellation of appointments**. We do understand that there are circumstances that may prevent you from keeping your child's appointment, however, with providing us as much notice as possible we may be able to contact another family who would like that appointment time. Afternoon appointments fill quickly, and canceling with less than 48 hours notice does not allow us enough time to schedule another patient in need of treatment. **After the second missed appointment, you will be asked to pre-pay for your child's appointment before we will reserve time on our schedule.** Patients that are running late are asked to call the office as soon as possible to check with the staff if they will still be able to keep their appointment. Also, cancellations are not accepted if left on the answering service and the appointment will not be considered cancelled unless you call during regular business hours and speak with one of our scheduling coordinators.

**Appointments cancelled with less than 48 hours notice on a school holiday, an after school time, or Saturday will not be rescheduled on another school holiday, Saturday or after school appointment time, as they are our most popular appointments.**

We greatly appreciate your cooperation in helping us provide you with excellent care for your family. Please sign below that you have read, and acknowledge the above information provided to you. We will provide a copy for your records.

**Patient/Guardian Signature**_____ **Date**_____

**Patient Name:** _____ **Date of Birth:** _____ **Date:** _____

# CHILD'S MEDICAL HISTORY

Child's Physician_____City/State_____Phone_____
Date of last physical exam_____Child's Vaccinations Updated YES NO
Current Medical Conditions_____
Any other specialist your child is currently seeing:_____

| | Type: | Reason: | How often: |
|---|---|---|---|
| **MEDICATIONS** | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

**List of ALLERGIES (*LATEX*, MEDICINES, FOODS., ETC):**_____

| | YES | NO | |
|---|---|---|---|
| Does your child have Congenital Heart Disease? | ____ | ____ | Is SBE prophylaxis required?_____ |
| Is child receiving any medication or drugs? | ____ | ____ | List Medications_____ |
| Has child ever been hospitalized? | ____ | ____ | Is so, why?_____ |
| Has child ever had surgery? | ____ | ____ | List surgeries_____ |
| Is there excessive bleeding when cut? | ____ | ____ | Handicaps/Disabilities?_____ |

**Does your child have, ever had or been diagnosed with any of the following (please check all that apply):**

**General**
__Complications during pregnancy/birth
__Prematurity
__Cleft Lip/Palate
__Inherited Disorders
__Syndrome:_____
__Problems of growth or stature
__Currently Pregnant

**Head, ears, eyes, nose, throat**
__Chronic adenoid/tonsil infections
__Chronic ear infections
__Ear Problems
__Hearing Impairments
__Eye Problems
__Visual Impairments
__Sinusitis
__Speech impairments
__Apena/Snoring
__Mouth Breathing

**Cardiovascular**
__Heart Problem/Surgery
__Rheumatic Fever/Rheumatic heart disease
__High/Low Blood Pressure
__Heart Murmur

**Respiratory**
__Asthma
Medications_____
Last Attack_____
Hospitalizations_____
__Frequent colds/coughs
__Reactive Airway Disease
__Tuberculosis
__RSV
__Breathing Problems
__Cystic Fibrosis
__Smoking

**Endocrine**
__Diabetes
__Growth Delays
__Hormonal Problems
__Precocious Puberty
__Thyroid Problems

**Integumentary**
__Fever blisters
_Eczema
_Rash/Hives
_Dermatologic Conditions
_Cold/Sores

**Gastrointestinal**
_Eating Disorders
_Ulcer
_Excessive Gagging
_Gastroesophageal/acid reflux disease
_Hepatitis A, B or C
_Jaundice
_Liver Disease
_Intestinal Problems
_Prolonged diarrhea
_Unintentional weight loss
_Lactose Intolerance
_Dietary Restrictions

**Genitourinary**
_Bladder Infections
_Kidney Infections
_Systemic Birth Control
__Sexual Transmitted Disease

**Musculoskeletal**
__Arthritis
_Scoliosis
_Bone/Joint Problems
_TMJ problems-popping/clicking/locking
_Problems opening mouth or chewing

**Neurologic**
_Fainting
_Dizziness
_Autism
_Developmental Disorders
_Learning Problems/Delay
_Mental Disabilities
_Brain Injury
_Cerebral Palsy
_Convulsions/Seizures/Epilepsy
_Hydrocephaly/Shunts

**Psychiatric**
__Emotional Disturbance
__Hyperactivity/ADHD/ADD
__Psychiatric problems/treatment
__Alcohol and chemical dependency

**Hematologic/lymphatic/immunologic**
__Anemia
__Blood Disorders
__Blood Transfusions
__Excessive Bleeding
__Bruising easily
__Hemophilia
__Sickle Cell Disease/Trait
__Cancer-Type:_____
__Immune disorder
__Chemotherapy
__Radiation Therapy
__Bone Marrow Transplant

**Infectious Disease**
___Measles
___Mumps
__Rubella
__Varicella (Chickenpox)
__Mononucleosis
__Cytomegalovirus (CMV)
__Whooping Cough
__Scarlet Fever
__HIV/AIDS

**Family History**
__Genetic Disorders
__Problems with General Anesthesia
__Serious Medical Conditions/Illness

**Social Concerns**
__Passive Smoke Exposure
__Recreational Drug Use
__Religious or Philosophical objections to treatment

**Other**
_____
_____

I understand the information I have provided is correct to the best of my knowledge. I understand it is my responsibility to inform this office of any changes in my child's medical status.
**Parent/Legal Guardian Signature:**_____ **Relationship to Child:**_____ **Date:**_____

**Nombre del paciente:** _____ **Fecha de nacimiento:** __/__/__ **Fecha:** __/__/__

# HISTORIA MEDICA DEL PACIENTE

Pediatra del paciente_____Ciudad/Estado_____Telefono_____
Fecha de examen físico _____Vacunación actualizadas SI NO
Condición medica actual_____
Liste a otros especialistas que su hijo esta viendo:_____

| | A que? | Porque? | Cuando? |
|---|---|---|---|
| **Medicamento** | _____ | _____ | _____ |
| | _____ | _____ | _____ |
| | _____ | _____ | _____ |

Lista de alergias (*LATEX*, COMIDA, PINTURAS, MATERIALES, etc)_____

| | SI | NO | |
|---|---|---|---|
| Su hijo(a) tiene cardiopatía congénita? | ____ | ____ | Es necesaria la profilaxis SBE?_____ |
| Está recibiendo alguna medicación o drogas? | ____ | ____ | Lista Medicamentos_____ |
| Su hijo(a) ha sido hospitalizado? | ____ | ____ | Por qué?_____ |
| Ha tenido alguna vez una cirugía? | ____ | ____ | Lista cirugías_____ |
| Hay sangrado excesivo cuando se corta? | ____ | ____ | Minusvalias/Discapacidad?_____ |

**HA TENIDO ALGUNA VEZ HISTORIA DE O DIFICULTAD CON CUALQUIERA DE LOS SIGUIENTES? (MARQUE LOS QUE APLICAN)**

## General
__Complicaciones al nacer
__Prematuro(a)
__Paladar Hendido
__Enfermedades Hereditarias
__Síndrome:_____
__Problemas de crecimiento o estatura
__Embarazada

## Cabeza, oidos, ojos, nariz, garganta
__Infecciones crónicas de garganta
__Infecciones crónicas de oídos
__Problemas de oídos
__Problemas de ojos
__Problemas de sinusitis
__Visual Imparmente
__Sinusitis
__Problemas de habla
__Apnea/roncar
__Mouth Breathing

## Cardiovascular
__Problems de Corazon/cirugia
__Soplo del Corazon
__Alta/Baja Presion
__Fiebre Reumatica

## Respiratorio
__Asma
Medicinas_____
Ultimo Ataque_____
Hospitalizaciones_____
__Resfriado/Gripe Frecuentes
__RSV
__Tuberculosis
__RSV
__Problemas Respiraorios
__Fibrosis Cistica
__Ciagarrillo

## Endocrino
__Diabetes
__Growth Delays
__Problemas Hormonales
__Precocious Puberty
__Problemas Tiroides

## Piel
__Fuegos en la boca
_Eccema (eczema)
_Erupción/Ronchas
_Condiciones dermatológicas
_Cold/Sores

## Gastrointestinal
_Desorden alimenticio
_Ulceras
_Nausea
_Enfermedades del Reflujo
_Hepatitis A B o C
_Ictericia (Jaundice)
_Problemas del Hígado
_Problemas Intestinales
_Diarrea Prolongada
_Unintentional weight loss
_Intolerancia a la lactosa
_Restrictions' Dietetics

## Genitourinario
_Infecciones de la vejiga
_Infecciones del Riñón
_Systemic Birth Control
_Enfermedades de transmisión sexual

## Musculo esquelético
__Artritis
__Escoliosis
_Bone/Joint Problems
_Problemas de Huesos/Articulaciones
_Problema al abrir la boca o masticar

## Neurologico
_Desamayos
_Mareos
_Autismo
_Desorden del Desarrollo
_Problemas de Aprendizaje/Retrasos
_Descapacidad Mental
_Dáno Cerebral
_Parálisis Cerebral
_Convulsiones/Ataques/Epilepsia
_Hidrocefalia/Derivaciones (Shunts)

## Psiquiátricos
__Problemas Psiquiátricos/Tratamiento
__Hiperactividad/ADDH (ADHD)
__Problemas Emocionales
__Alcohol and chemicol dependencia

## Hematologico/Linfático/Immune
__Anemia
__Desorden sanguíneo/enfermedad de sangre
__Transfusiones de sangre
__Sangrado Excesivo
__Moretones Fácilmente
__Hemofilia
__Enfermedad de la Célul de Hoz
__Cáncer-Tipo:_____
__Enfermedad Immune
__Quimioterapia
__Terapia de Radiación
__Trasplanté Médula Ósea

## Enfermedades Infecciosas
___Sarampión
___Paperas
__Rubeola
__Varicela
__Mononucleosis
__Cytomegalovirus (CMV)
__Whooping Cough
__Scarlet Fever
__SIDA/HIV

## Historia Familiar
__Desorden Genéticos
__Problemas con Anestesia General
__Condiciones/enfermedades medicas graves

## Preocupaciones Sociales
__Expuesto al humo de cigarrillo
__Historia de drogas./abuso de alcohol
__Objeción a tratamiento por razón religiosa

## Other
_____
_____

Mi firma indica que yo entendí y he contestado todas las preguntas en esta historia médica correctamente de acuerdo a mi conocimiento. Yo entiendo que es mi responsabilidad de informar a esta oficina de algún cambio en el estado medico de mi hijo(a).

**Firma de Padre/Apoderado legal:**_____**Parentezco al Paciente:**_____**Fecha:**_____