ROSE E. KIM, DDS
AND
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VALENCIA SMILES
Orthodontics & Pediatric Dentistry

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# Patient Registration

Name:______________________________________________ ❑ Male ❑ Female

Nickname: ______________ DOB ________________ Age:_______________

Home Address:______________________ City:______________ Zip Code: ________

School: ________________ Grade:_______ Hobbies/Sports_____________________

Is your child adopted? ❑ Yes ❑ No If yes, does she/he know? ❑ Yes ❑ No

**Is there anything else that you would like us to know about your child?** _______________

How did you hear about our office? _____________________________________

# Person(s) Responsible for Account

## Parent/Legal Guardian #1

Name:__________________________________ Marital status: ____________

Home Address:______________________ City:______________ Zip Code: ________

Date of birth: _____________________ Relationship to child: _______________

Email: ___________________________________ Phone : _______________

Employer: ________________________ Occupation: ______________________

## Parent/Legal Guardian #2

Name:__________________________________ Marital status: ____________

Home Address:______________________ City:______________ Zip Code: ________

Date of birth: _____________________ Relationship to child: _______________

Email: ___________________________________ Phone : _______________

Employer: ________________________ Occupation: ______________________

# Insurance Information

Primary Policy Holder Name: ____________________________________________

SSN: _____________________________ DOB:______________________________

Dental Insurance:_________________ Group #:_______ Subscriber ID# _______________

**If you have Dual Coverage**

Secondary Policy Holder Name: __________________________________________

SSN: _____________________________ DOB:______________________________

Dental Insurance:_________________ Group #:_______ Subscriber ID# _______________

**I authorize my insurance benefits to be paid directly to Valencia Smiles. In addition, I authorize Valencia Smiles to release any information required for all insurance claims. I accept full financial responsibility for all charges not covered by insurance benefits. I also understand that where appropriate, credit bureau reports may be obtained.**

_____________________________________________ ____________________

Signature ( Parent or Legal Guardian) Date

Please print name: ______________________________________________

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## Medical History

Child's Physician ______________________________ Phone: ______________

Is your child in good health? ❑ Yes ❑ No    Has puberty begun? ❑ Yes ❑ No

Please list any medications your child is currently taking: ______________________________

Please list any allergies to medication: ______________________________

Any allergies to: ❑ Plastic ❑ Metals ❑ Latex ❑ Dye ❑ Food: ______________________________

**Is there a medical condition requiring antibiotic coverage for dental treatment?** ❑ Yes ❑ No

**Has your child ever had any of the following conditions (Please answer for each condition):**

| Condition | YES | NO | Condition | YES | NO | Condition | YES | NO | Condition | YES | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Abnormal Bleeding | ❑ | ❑ | Bone/Joint Disease | ❑ | ❑ | Diabetes | ❑ | ❑ | Kidney Disease | ❑ | ❑ |
| ADHD/ADD | ❑ | ❑ | Cancer | ❑ | ❑ | Epilepsy/Seizure Disorder | ❑ | ❑ | Pregnancy | ❑ | ❑ |
| AIDS/HIV+ | ❑ | ❑ | Cerebral Palsy | ❑ | ❑ | Feeding tube | ❑ | ❑ | Rheumatic/Scarlet Fever | ❑ | ❑ |
| Anemia | ❑ | ❑ | Cleft Lip/Palate | ❑ | ❑ | GERD | ❑ | ❑ | Surgeries | ❑ | ❑ |
| Anorexia/Bulimia | ❑ | ❑ | Chronic Sinus, Ear, Adenoid/ Tonsil infections | ❑ | ❑ | Hearing/ Speech Impairments | ❑ | ❑ | Tuberculosis | ❑ | ❑ |
| Asthma | ❑ | ❑ | Congenital Heart Defects | ❑ | ❑ | Hemophilia | ❑ | ❑ | Visual impairments | ❑ | ❑ |
| Autism | ❑ | ❑ | Cystic Fibrosis | ❑ | ❑ | Hepatitis/ Liver disease | ❑ | ❑ | Special Needs | ❑ | ❑ |
| Birth Defects/ Genetic Disorders | ❑ | ❑ | Developmental Delay | ❑ | ❑ | Hospitalizations | ❑ | ❑ | | | |

Other/Please Specify: ______________________________

## Dental History

Previous Dentist: ______________________________ Last dental visit: ______________

What is your primary concern regarding your child's oral health? ______________________________

Has your child had an orthodontic evaluation? ❑ Yes ❑ No    Any specific orthodontic concerns? ______________

**Has your child ever had any of the following conditions (Please answer each condition):**

| Condition | YES | NO | Condition | YES | NO | Condition | YES | NO | Condition | YES | NO |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Injury to face, teeth, jaw | ❑ | ❑ | Clenching/grinding | ❑ | ❑ | Lip sucking/biting | ❑ | ❑ | Removal of Tonsils | ❑ | ❑ |
| Pain/discomfort in jaw joint | ❑ | ❑ | Mouth breathing/snoring | ❑ | ❑ | Pacifier habit | ❑ | ❑ | Missing or extra permanent teeth | ❑ | ❑ |
| | | | Nail biting | ❑ | ❑ | Thumb/ finger sucking | ❑ | ❑ | | | |
| Severe gag reflex | ❑ | ❑ | Tongue thrusting | ❑ | ❑ | Removal of Adenoids | ❑ | ❑ | Cavities | ❑ | ❑ |

## Infant/ Toddler Questionnaire

Are you currently breast/ bottle feeding your child? ❑ Yes ❑ No    When did you stop? ______________

Does/Did your child sleep with a bottle or fall asleep after nursing? ❑ Yes ❑ No

Has your child had a tongue tie release? ❑ Yes ❑ No

At what age did your child's first tooth appear? ______________    How often do you brush your child's teeth? ______________

Do you floss your child's teeth? ❑ Yes ❑ No    Does your child's toothpaste contain fluoride? ❑ Yes ❑ No

## Consent for Treatment

I understand that the information that I have provided is correct to the best of my knowledge and that it will be held in the strictest of confidence. It is my responsibility to inform the office of any changes in my child's medical history.

The undersigned hereby authorize Dr. Rose Kim and Dr. Kathleen Mulcahey and/or associates and auxiliary personnel to perform dental care for my child. This consent shall be active until cancelled by either party.

______________________________ ______________

Signature (Parent or Legal Guardian)    Date

______________________________ ______________

Reviewed by    Date