

ROSE E. KIM, DDS
AND
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Patient Registration

Name: _____ Male Female

Nickname: _____ Date of Birth: _____ 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: _____ Date of Birth: _____

SSN: _____ Subscriber/Member ID#: _____

Dental Insurance: _____ Group #: _____

If you have Dual Coverage

Secondary Policy Holder Name: _____ Date of Birth: _____

SSN: _____ Subscriber/Member ID#: _____

Dental Insurance: _____ Group #: _____

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: _____

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):

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

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):

	YES	NO		YES	NO		YES	NO		YES	NO
Injury to face, teeth, jaw	<input type="checkbox"/>	<input type="checkbox"/>	Clenching/grinding	<input type="checkbox"/>	<input type="checkbox"/>	Lip sucking/biting	<input type="checkbox"/>	<input type="checkbox"/>	Removal of Tonsils	<input type="checkbox"/>	<input type="checkbox"/>
Pain/discomfort in jaw joint	<input type="checkbox"/>	<input type="checkbox"/>	Mouth breathing/snoring	<input type="checkbox"/>	<input type="checkbox"/>	Pacifier habit	<input type="checkbox"/>	<input type="checkbox"/>	Missing or extra permanent teeth	<input type="checkbox"/>	<input type="checkbox"/>
Severe gag reflex	<input type="checkbox"/>	<input type="checkbox"/>	Nail biting	<input type="checkbox"/>	<input type="checkbox"/>	Thumb/ finger sucking	<input type="checkbox"/>	<input type="checkbox"/>	Cavities	<input type="checkbox"/>	<input type="checkbox"/>
			Tongue thrusting	<input type="checkbox"/>	<input type="checkbox"/>	Removal of Adenoids	<input type="checkbox"/>	<input type="checkbox"/>			

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