JEAN CHAN DDS AND ASSOCIATES
PEDIATRIC DENTISTRY
GET ACQUAINTED QUESTIONNAIRE
www.healthygrins.com

Name_____**Nickname**_____**Age**____**DOB**_____
Child attends what school? _____ Male / Female
Is this an emergency visit? Yes / No
Is this the first visit to a dentist? Yes / No
Date of last dental visit? _____
Name of former dentist? _____
Has any member of your family been a patient of this office before? Yes / No
Name(s)_____
Present dental problem as you see it (if any) _____
Home Address_____
Street City Zip How Long?
Home Phone No._____ **Join our E-mail List:** _____
Father's Name_____ Social Sec No. _____
Employer Name_____ Work Phone_____
Address _____ Cell Phone _____
Occupation _____ DOB _____ Drivers License No._____
Mother's Name_____ Social Sec No._____
Employer: Name_____ Work Phone _____
Address _____ Cell Phone _____
Occupation _____ DOB _____ Drivers License No. _____
Name of Parent or Legal Guardian with whom child lives_____
Name of Parent Financially responsible_____
Name, Address and Phone Number of person to bill (if different from Home Address)?
_____
Name Phone No. Street City State Zip
Name of friend or relative in this area _____Phone No._____
Whom may we THANK for **referring** you to our office? _____
Do you have **DENTAL INSURANCE**? Yes____ No____
Name of Dental Insurance: _____
Insurance Address: _____
Insurance Phone Number _____Group No_____
Secondary Insurance: _____
Insurance Address: _____
Insurance Phone Number _____Group No_____

Dental History
How do you think your child will act toward the dentist? _____
Has your child had any history of: **PLEASE CIRCLE**
thumb sucking **finger sucking** **nail biting** **prolonged bottle usage**
pacifier **lip sucking** **tooth grinding** **extended nursing**
Has your child ever had an unfavorable experience in a previous dental (or medical) office? ..... Yes / No
Has Mother or Father had a lot of decay?..... Yes / No
Is your child taking any supplemental Fluoride?..... Yes / No
Has your child experienced injuries to the mouth, teeth, or jaws?..... Yes / No
Has your child been seen or treated by an ORTHODONTIST? .....Yes / No
If yes, who_____ Last seen? _____

Medical History
IS YOUR CHILD In good health.....Yes / No
Name of child' physician_____ Phone No._____
Now under the care of a physician..... Yes / No Date of last visit _____
Is your child currently taking any medications?..... Yes / No Please list_____

(Please Complete Other Side)

Has your child had any history of the following: **(PLEASE CIRCLE, If YES circle individual issue)**

Y N Congenital heart disease, heart murmur or heart damage from rheumatic fever
Please explain_____ **Need for Antibiotic Prophylaxis? Y___ N ___**

Y N Blood disorders, bleeding problems, anemia or sickle disease

Y N Seizure disorders, epilepsy, convulsions, cerebral palsy, or brain injury

Y N Sight or hearing disorders or other limitations

Y N Asthma, pneumonia, tuberculosis, cystic fibrosis, or other breathing difficulties

Y N Stomach, intestinal, kidney or liver problems, including jaundice or hepatitis

Y N Diabetes, thyroid disorders, or other glandular problems

Y N Immune system disorders, including HIV infection or Aids

Y N Cancer, tumors, or growths

Y N Joint or limb problems, including arthritis, or muscle problems or weaknesses

Y N Behavioral problems, attention disorders, or communication problems

Y N **ALLERGIES** to Latex rubber.....

Y N **ALLERGIES** or sensitivities to any **drugs or medications: Please Explain:_____**

_____

Has your child been hospitalized in the past 2 years? Yes / No Please explain_____

Are there other medical problems, flu, any other Aerosol transmissible diseases, or conditions you feel should be brought to our attention? Yes / No

If yes, please explain_____

Consent to Treat Minor

As parents/guardians of _____ we hereby give Jean Chan DDS, Associates, and staff, authorization, following an explanation of the procedures, methods, and medications involved, to perform all necessary diagnostic, preventive, restorative, surgical, orthodontic, and associated dental treatment for my above named child. The information I have provided is to the best of my knowledge accurate and complete. I authorize and consent to the release of all information concerning my child's dental health and treatment history to third party payers and to other health professionals. This consent is to remain in effect until cancelled in writing. I hereby state that I have read and understand this informed consent and that I will be responsible for any financial obligations incurred for dental treatment. I am legally authorized to provide medical/dental consent.

Signature Parent/Legal Guardian_____ Date_____

Relationship to Child _____

Appointments: Each appointment represents a specific amount of time reserved for your child's dental care. We request **48 hour notification** if you are not able to keep the appointed time reserved. Changes or cancellations made with less than 48 hours notice may result in a **$55 charge**.

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You have the right to refuse to sign this Acknowledgment

Date:_____

I,_____, have received a copy of this office's *NOTICE OF PRIVACY PRACTICES* as
(Signature of parent/legal guardian of patient)
required by federal law.

_____ _____

Print Patient's Name **Print Parent/Legal Guardian's Name**

FOR OFFICE USE ONLY

On the date above we made a good faith effort@ to obtain written acknowledgment of receipt of our ***NOTICE OF PRIVACY PRACTICES***. We were unable to obtain acknowledgment for the following reason:

____Patient refused to sign ____Other _____
(Possible reasons: Language difficulty, communication barriers, dental emergency)

_____ _____

(Printed Name) **(Signature of employee attempting to gain acknowledgment)**