Please print this form, fill it out and bring with you to your first visit.

TUSTIN PEDIATRIC DENTISTRY

Michael J. McCartney, D.D.S. and Associates

Welcome to our practice! We pledge to render the finest pediatric dental care possible for your family.
Thank you in advance for providing the information requested below. Today's Date: ________/________/________

CHILD (PATIENT) INFORMATION

Child's name______________________ Nickname______________________ Gender: M______ F______

Age__________ Date of Birth______________________ Birthplace______________________

Reason for this dental visit______________________

Whom may we thank for referring you to our office?______________________

Name, address and phone # of child's pediatrician/physician______________________

Person responsible for child's account______________________ Responsible person's SS #______________________

Is child covered by a dental plan or dental insurance__________ Yes_____ No_____ If yes, which one______________________

PARENT / GUARDIAN INFORMATION

Father's name______________________ Occupation______________________

Employed by______________________ Address______________________

Mother's Name______________________ Occupation______________________

Employed by______________________ Address______________________

Indicate YOUR relationship to patient (circle one) __________ Parent__________ Grandparent______ Guardian________ Other__________

Status of primary parent or caregiver (circle one) __________ Married ________ Widowed ________ Divorced________ Other__________

If divorced, can you make (check one) ________Health care decisions on your own, or ________Health care decisions need both parents

Home address______________________ City______________ Zip code______________

Home phone______________________ E-mail address______________________

Father's cell phone #______________________ Mother's cell phone #______________________

Name and address of closest relative______________________ Phone #______________________

For each parent with dental insurance, your Date of Birth and Social Security Number are required by insurance companies in order for us to submit claims on your behalf. You need only provide information below for each parent that has dental insurance

Father: Date of Birth______/______/______ SS#______________ Mother: DOB______/______/______ SS#______________

CHILD'S GENERAL HEALTH QUESTIONNAIRE (Use reverse side if needed for complete answers)

State the general condition of child's health. Please give detail.______________________

____

	YES	NO
Has your child ever been under the care of a physician?	O	O
If yes, for what, when and give name of physician______________________		
Has your child received medication in the past other than antibiotics?	O	O
If yes, for what and when______________________		
Has your child ever had any type of surgery?	O	O
If yes, for what, when and by whom______________________		

Has your child had any history of the following?

	YES	NO		YES	NO
Heart trouble	O	O	Asthma	O	O
Heart murmur	O	O	Bleeding disorder	O	O
Rheumatic fever	O	O	Attention Deficit Disorder (ADD)	O	O
Brain injury	O	O	Attention Deficit Hyperactivity Disorder (ADHD)	O	O
Fainting / Seizures	O	O	Sight or hearing limitations	O	O
Epilepsy / Convulsions	O	O	Immune system disorders (including HIV or AIDS)	O	O
Diabetes	O	O	Cancer, tumors or growths	O	O
Hepatitis / Jaundice	O	O	Gastric reflux (GERD)	O	O
Kidney disease	O	O	Other		

Is your child allergic to or has he/she had a reaction to any of the following

	YES	NO	
Local anesthetics (such as Novocain)	O	O	If yes, what______________________
Penicillin, Amoxicillin or other antibiotic	O	O	If yes, what______________________
Aspirin or other analgesics	O	O	If yes, what______________________
Latex rubber	O	O	If yes, what______________________
Any metals (such as Nickel or Tin)	O	O	If yes, what______________________
Any other food, drug or medication allergy	O	O	If yes, what______________________

PATIENT DENTAL HISTORY

	YES	NO
Is this your child's first dental visit?	O	O
If NO, Previous dentist ____ City/State ____ May we contact	O	O
Approximate date of last dental visit ____ Approximate date of last dental X-rays ____		
Has your child ever taken (swallowed) a fluoride vitamin or fluoride tablet?	O	O
Has your child had topical fluoride gel applied to his/her teeth in a dental office?	O	O
Has your child experienced any unfavorable reaction from any previous medical or dental care?	O	O
If yes, what ____		
Has there ever been any injury to any of your child's teeth as a result of a fall, blow, bump or other incident?	O	O
If yes, what and when ____		
Does your child have any oral habits such as thumb/finger sucking, baby bottle, pacifier, other?	O	O
If yes, what and how frequent ____		
Are you aware of any current dental problems which you expect will require treatment?	O	O
Has your child ever had a toothache or tooth pain?	O	O
Has your child been seen or treated by an orthodontist?	O	O
Has any member of your family ever had an unusual dental history, such as missing or extra teeth?	O	O
If yes, what and who ____		
Are there any other health problems or concerns that you feel should be brought to the attention of the doctor?	O	O

If yes, please explain ____

I hereby certify the foregoing information is true and correct, to the best of my knowledge:

Signature ____ Relationship to patient ____

GENERAL CONSENT

The undersigned hereby authorizes the pediatric dental specialists of this group, following explanation of the procedure(s) involved, to perform any and all forms of treatment, medication and therapy, that may be indicated in connection with the care of the above named child and further authorizes and consents that the group dentists may choose and employ such assistance as the deem fit. The undersigned understands that previous to treatment, full explanation of procedure(s) involved will be given by one of the pediatric dental specialists and/or their staff. 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; any exceptions are indicated below. This consent is to remain in effect until canceled in writing.

Signature ____ Relationship to patient ____ Date ____

Specific exceptions to my consent to the release of information concerning my child's dental health and treatment history ____

Reviewed by Dr. ____ Date ____