Angeli J. Thakker, D.D.S.
Bellevue Pediatric Dentistry, P.C.

Patient Information

Patient Name _____ Date _____
Last First MI (Preferred Name)
Gender_____ Social Security # _____ Birth Date _____
Name of Guardian _____ Phone (Home) _____
Guardian (Work) _____ Best time to call _____ E-mail _____
(Cell) _____ (Emergency) _____
Address _____
Street Apartment #
_____
City State Zip Code

Guardian or Responsible Party Information

The following is for : ☐ the patient's guardian ☐ the person responsible for payment
Name _____
☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other _____
Social Security # _____ Birth Date _____
Phone (Home) _____ (Work) _____ Ext _____ Best time to call _____
Address _____
Street Apartment #
_____
City State Zip Code
Employer Name _____ Occupation _____
Address_____
Street City State Zip Code Phone

Insurance Information

Primary
Name of Insured _____ Insured's S.S. # _____
Last First MI
Insured's Birth Date _____ ID # _____ Group # _____
Insured's Address _____
Street City State Zip Code
Insured's Employer Name _____
Address _____
Street City State Zip Code
Patient's relationship to insured ☐ Self ☐ Spouse ☐ Child ☐ Other _____
Insurance Plan Name and Address _____
_____

Secondary
Name of Insured _____ is insured a patient? ☐ Yes ☐ No
Last First MI
Insured's Birth Date _____ ID # _____ Group # _____
Insured's Address _____
Street City State Zip Code
Insured's Employer Name _____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient ☐ Dental Office ☐ Physician ☐ Yellow Pages
☐ Google ☐ Bing ☐ Yahoo ☐ Insurance Company ☐ Flyer ☐ Other _____
Name of person or office referring you to our practice: _____

CONSENT FOR TREATMENT

I hereby authorize the doctor and/or her staff to take radiographs, study models, photographs or any other diagnostic aids deemed appropriate by the doctor to make a thorough diagnosis of the patient's dental needs. I further authorize and consent that the doctor choose and employ such assistance as she deems fit. I understand the use of anesthetic agents embodies a certain risk.

The treatment plan has been explained to me. All questions relative to its content, necessity and scope including alternate options have been answered to my satisfaction and I agree to it.

I understand that the responsibility for payment of dental services provided in this office for my dependents is mine, due and payable at the time services are rendered, regardless of insurance coverage, unless other financial arrangements have been made. Insurance is not a guarantee of benefits. Please provide all active primary and secondary dental insurance information at the time of dental appointment.

_____ _____

Signature Date

Relation to patient: Parent / legal guardian

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You may refuse to sign this Acknowledgement*

I, _____, have received a copy of
(Please Print Name)

this office's Notice of Privacy Practices

_____ _____

Signature Date

Relation to patient: Parent / Legal guardian

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

MEDICAL HISTORY

1) Does your child have any health problems? ☐ Yes ☐ No
   If yes, explain_____
2) Is your child currently seeing a physician for any problems? ☐ Yes ☐ No
   If yes, explain_____
3) Did your child have any health problems or illnesses when younger ☐ Yes ☐ No
   If yes, explain_____
4) Does your child take any medications? ☐ Yes ☐ No
   If yes, please list including dose_____
   _____
5) Does your child have any allergies? ☐ Yes ☐ No
   If yes, explain_____
6) Has your child ever been injured or stayed in a hospital overnight? ☐ Yes ☐ No
   If yes, explain_____
7) Is your child pregnant or has been pregnant in the past? ☐ Yes ☐ No
   Is the child taking a contraceptive pill? ☐ Yes ☐ No
8) Has your child ever had a blood transfusion? ☐ Yes ☐ No
9) Has your child ever had any of the following? ☐ Yes ☐ No
   - Blood problems such as sickle cell anemia ☐ Yes ☐ No
   - Easy bleeding or bruising ☐ Yes ☐ No
   - Seizures or fainting spells ☐ Yes ☐ No
   - Frequent headaches ☐ Yes ☐ No
   - Heart murmur, heart defect or rheumatic heart fever ☐ Yes ☐ No
   - Breathing problems or asthma ☐ Yes ☐ No
   - Tuberculosis (T.B.) ☐ Yes ☐ No
   - Hepatitis or liver problems ☐ Yes ☐ No
   - Stomach or bowel problems ☐ Yes ☐ No
   - Diabetes (sugar), endocrine or hormone problems ☐ Yes ☐ No
   - Kidney problems ☐ Yes ☐ No
   - Hives or skin rash ☐ Yes ☐ No
   - AIDS or HIV infection ☐ Yes ☐ No
   - Venereal disease ☐ Yes ☐ No
   - Birth defect or disability ☐ Yes ☐ No
10) Does your child have any behavior or learning problems? ☐ Yes ☐ No
    What grade at school is he/she in?_____
11) Has your child had any disease or condition not listed above? ☐ Yes ☐ No
    If yes, explain_____
12) Name of your child's pediatrician or family physician_____
    Address _____ Phone _____
    Date of last physical examination _____

TO THE BEST OF MY KNOWLEDGE THE ABOVE INFORMATION IS COMPLETE AND ACCURATE

_____ _____
SIGNATURE OF PARENT/ LEGAL GUARDIAN DATE

DENTAL HISTORY

1. Why did you bring your child to the dentist today?_____

   _____

   _____

2. Is this his/her first visit to the dentist? ☐ Yes ☐ No

   If no, date of last examination_____

   Type of treatment received ☐ Cleanings ☐ Fillings ☐ Emergency care

   Have you been satisfied with your child's past dental treatment? ☐ Yes ☐ No

   If no, why not?_____

3. Has your child cried or been upset during previous dental or medical care? ☐ Yes ☐ No

   If yes, explain_____

   Do you think he or she will cry or be upset for dental treatment today? ☐ Yes ☐ No

   If yes, explain_____

4. Has your child ever had any of the following problems? (Please check all that apply)

   ☐ Finger or thumb habits
   ☐ Pacifier habit
   ☐ Clenching or grinding teeth
   ☐ Mouth breathing
   ☐ Speech problems
   ☐ Toothaches
   ☐ Abscesses (gum boils)
   ☐ Bleeding gums
   ☐ Injury to face, mouth or front teeth
   ☐ TMJ problems

5. Does or did your child ever go to bed with the bottle? ☐ Yes ☐ No

   How old was he/she when he/she no longer used a bottle?_____

6. Does your child use a sippy cup? ☐ Yes ☐ No

7. How often are your child's teeth brushed?_____

8. How often does he/she floss?_____

9. Does the toothpaste you use for your child contain fluoride ☐ Yes ☐ No

10. What beverage does your child drink most often ?_____

11. What type of water do you drink at home?

    ☐ Tap water ☐ Reverse osmosis filtered ☐ Bottled water ☐ Refrigerator filtered ☐ Other

12. What does your child typically eat for snacks?_____