WELCOME

We are pleased to welcome you and your child to our practice.
Please take a few minutes to fill out this form as completely as you can.
If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

JOANN TOY, D.M.D.
901 Campus Drive, Suite 212
Daly City, CA 94015

Date ______________________

PATIENT INFORMATION

Name of Minor / Child ____________________ (Last Name) ____________________ (First Name) ______ (Initial)

Sex ☐ M ☐ F Age ______ Birthdate ______________ Nickname ______________ Hobbies ______________

Home Address ____________________ (Street) ______________ (City) ______ (State) ______ (Zip)

Mailing Address ____________________ (Street) ______________ (City) ______ (State) ______ (Zip)

Person financially responsible ______________________ Home Phone ______________________

Work Phone ______________________ Cell Phone ______________________

Whom may we thank for referring you? ______________________

INSURANCE

Father's / Guardian's Name ______________________

Address (if different from patient's) ______________________

____

Home Phone ______________ (if different from above) Work Phone ______________ (if different from above)

Cell Phone ______________________

Employer ______________________

Occupation ______________________

Soc. Sec. # ______________ Birthdate ______________

Driver's Lic. # ______________________

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name ______________________

Phone No. ______________________

Address ______________________

Group # ______________ Policy # ______________

Mother's / Guardian's Name ______________________

Address (if different from patient's) ______________________

____

Home Phone ______________ (if different from above) Work Phone ______________ (if different from above)

Cell Phone ______________________

Employer ______________________

Occupation ______________________

Soc. Sec. # ______________ Birthdate ______________

Driver's Lic. # ______________________

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name ______________________

Phone No. ______________________

Address ______________________

Group # ______________ Policy # ______________

DENTAL HISTORY

Date of last visit to a dentist ______________ For what service? ______________

Name of Dentist ______________________

	YES	NO
Has child complained about dental problems?	☐	☐
Does child brush teeth daily?	☐	☐
Does child use floss every day?	☐	☐
Is fluoride taken in any form?	☐	☐
Any injuries to mouth, teeth, head?	☐	☐
Any unhappy dental experiences?	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?	☐	☐

Please Complete Both Sides

MEDICAL HISTORY

Minor/Child's Physician ____________________ City/State ____________ Phone ____________

Date of last physical examination ____________ Results ____________________

	YES	NO	
Is Minor/Child under care of physician now?	☐	☐	Medications ____________
Receiving any medication or drugs?	☐	☐	____________
Ever been hospitalized?	☐	☐	____________
Ever had surgery?	☐	☐	Allergies ____________
Is there excessive bleeding when cut?	☐	☐	____________

HAS MINOR/CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING?

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	A.I.D.S./H.I.V.	☐	☐	Cerebral Palsy	☐	☐	Epilepsy	☐	☐	Kidney Disease	☐	☐	Rheumatic Fever
☐	☐	Anemia	☐	☐	Chicken Pox	☐	☐	Fainting	☐	☐	Liver Disease	☐	☐	Sinus Problems
☐	☐	Asthma	☐	☐	Convulsions	☐	☐	Hearing Problems	☐	☐	Measles	☐	☐	Thyroid Disease
☐	☐	Autism	☐	☐	Developmental Delay/Speech	☐	☐	Heart Problems	☐	☐	Mononucleosis	☐	☐	Tuberculosis
☐	☐	Bladder Problems	☐	☐	Diabetes	☐	☐	Hepatitis	☐	☐	Mumps	☐	☐	Other
☐	☐	Cancer	☐	☐	Drug/Alcohol Abuse									

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name ____________________ Relationship ____________ Phone ____________

Name ____________________ Relationship ____________ Phone ____________

AUTHORIZATION

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

____

Signature of Parent/Guardian

____

Date

I certify that my minor child is covered by insurance with:

____

Name if Insurance Company(ies)

and assign directly to Dr. ____________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

____

Signature of Parent/Guardian

____

Date

UPDATE

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe ____________________

Is patient taking any new medications? ☐ Yes ☐ No If yes, please list ____________________

Date ____________ Parent/Guardian Signature ____________________

Date ____________ Dentist Signature ____________________

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