

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 _____ Phone No. _____

Name of friend or relative in this area _____

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)