# Dena Marcus D.D.S.  Claire Tyler D.D.S.

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**Sonoma, Ca 95476** **admin@sonomafamilydentist.com e-mail**

Child's Name_____ Birth Date:_____ Today's Date _____

Medical Doctor _____ Phone _____ Date of last visit _____

Previous Dentist _____ Phone _____ Date of last visit _____

Person to contact in case of Emergency: _____ Phone _____ Relation _____

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

**[ ] Mother [ ] Father [ ] Guardian [ ] Other** _____ Name: _____ [ ] Married [ ] Single

Social Security #:_____ Birth Date:_____ Driver's License #: _____ State_____

Home Address: _____ City _____, State____ Zip_____

Phone (Home) _____ (Work)_____ (Cell)_____ Email _____

Employer: _____ Occupation _____

**[ ] Mother [ ] Father [ ] Guardian [ ] Other**_____ Name: _____ [ ] Married [ ] Single

Social Security #:_____ Birth Date:_____ Driver's License #: _____ State_____

Home Address: _____ City _____, State____ Zip_____

Phone (Home) _____ (Work)_____ (Cell)_____ Email _____

Employer: _____ Occupation _____

**INSURANCE INFORMATION or Provide Your Insurance Card**

Primary Insurance: Name of Insured _____ Relationship to patient:_____

Insured's birth date: _____SS#_____ Is insured a patient? [ ] Yes [ ] No

Insured's address: _____ City, State &Zip _____

Insured's employer: _____ Group # _____

Insurance Company: _____ Insurance Phone #_____ Insurance address: _____

Secondary Insurance: Name of Insured _____ Relationship to patient: _____

Insured's birth date: _____SS#_____ Is insured a patient? [ ] Yes [ ] No

Insured's address: _____ City, State &Zip _____

Insured's employer: _____ Group # _____

Insurance Company: _____ Insurance Phone #_____Insurance address: _____

**Office Use Only**: Doctor's Comments

_____

_____

_____ Signature: _____ Date:_____

## HEALTH & DENTAL INFORMATION

**Is your child under medical treatment now?** []Yes [ ] no. If yes _____

Has your child been admitted to a hospital or needed emergency care during the past two years? [ ] Yes [ ] No. If yes explain_____

**Is your child taking any medication (s) including non-prescription medicine and supplements** [ ]Yes [ ] No **Fluoride ?** [ ] Yes [ ] No

If Yes, please list ALL medications being taken :_____

_____

**Has your child had any reactions to the following:** Local Anesthetics [ ] Yes [ ]No

Penicillin or any other Antibiotics?_____ [ ]Yes [ ]No Sulfa Drugs [ ] Yes [ ] No

Any Metals (nickel) _____ [ ] Yes [ ]No Latex [ ] Yes [ ] No

Other (please list) _____

**Does your child have or had any of the following? (please mark yes or no)**

| Yes | No | | Yes | No | | Yes | No | | Yes | No | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| [ ] | [ ] | Aids/HIV | [ ] | [ ] | Epilepsy/convulsions | [ ] | [ ] | Hepatitis, Type _____ | [ ] | [ ] | Recreational Drugs |
| [ ] | [ ] | Anemia | [ ] | [ ] | Excessive Bleeding | [ ] | [ ] | High Blood Pressure | [ ] | [ ] | Respiratory problem |
| [ ] | [ ] | Angina | [ ] | [ ] | Fainting/Seizures | [ ] | [ ] | Jaundice | [ ] | [ ] | Rheumatic Fever |
| [ ] | [ ] | Arthritis | [ ] | [ ] | Hemophilia | [ ] | [ ] | Joint replacement/implant | [ ] | [ ] | S.T.D's |
| [ ] | [ ] | Asthma | [ ] | [ ] | Growths | [ ] | [ ] | Kidney disease | [ ] | [ ] | Smoke/use tobacco |
| [ ] | [ ] | Cancer | [ ] | [ ] | Hay Fever/allergies | [ ] | [ ] | Low Blood Pressure | [ ] | [ ] | Tonsils Out |
| [ ] | [ ] | Chest Pains | [ ] | [ ] | Head Injuries_____ | [ ] | [ ] | Mental or nervous disorder | [ ] | [ ] | Thyroid problem |
| [ ] | [ ] | Diabetes | [ ] | [ ] | Heart attack_____ | [ ] | [ ] | Mitral valve prolapse | [ ] | [ ] | Tuberculosis |
| [ ] | [ ] | Dizziness | [ ] | [ ] | Heart disease | [ ] | [ ] | Pacemaker/shunt | [ ] | [ ] | recent smallpox vaccine |
| [ ] | [ ] | Phen-Fen, R edux | [ ] | [ ] | Heart murmur | [ ] | [ ] | Radiation therapy | [ ] | [ ] | other_____ |

Have your child ever had any complications following dental treatment? [ ] Yes [ ] No _____

Any Health or Dental Issue that has not been addressed that could influence treatment or needs further clarification?

_____

_____

### Financial Agreement and Release

**Financial arrangements must be made in advance. As a courtesy, we will be happy to assist you in the billing and collection from your insurance company. However you are responsible for all charges and we do not take any responsibility for services not paid by your insurance company. Your portion is due at the time services are rendered. Accounts not paid in full by the end of the first billing cycle will have a late charge of 1.8%. Returned checks are subject to a $25 fee.**

**Appointments cancelled without 24hr business day notice will be charged $50.**

**I authorize the release of any information including the diagnosis and the records of any treatment or exam rendered to me during the period of such dental care to third party payers and/or health practitioners.**

X_____Date_____ **Relationship to patient**_____

Signature of responsible party