



CONFIDENTIAL

MEDICAL & DENTAL HISTORY

Name _____ Birth date _____ Today's Date _____

Reason for today's visit _____

Date of your child's last dental visit _____ What was done then _____

How many times a day does your child brush? _____ Floss? _____

Does or has your child:

Table with 4 columns: Condition, YES, NO, YES, NO. Rows include Suck Thumb/Finger, Clench or Grind their teeth, Bite or chew fingernails, Suck/Bite Lips or Cheek, Chew hard objects (pencils etc.), Had any head/neck/jaw injuries?

Although we primarily treat the area in and around your mouth, any health problems, and medication that you may be taking can have an effect on the dental care we provide for you. Thank you for answering the following medical health questions.

Is your child in good health? Yes No _____ Is your child under the care of a physician now? Yes No _____
Has your child been hospitalized since birth? _____ If so, why? _____

Please list any medications, including non-prescription: _____

Has your child ever had any of the following:

Table with 2 columns: Yes No, Yes No. Lists various medical conditions like Rheumatic heart disease, Diabetes, Epilepsy, etc.

Does your child have any disease, condition, or problem not listed that you think I should know about? _____

Physician's Name _____ Physician's Phone #: _____

PLEASE READ CAREFULLY BEFORE SIGNING. IF YOU HAVE QUESTIONS OR DO NOT UNDERSTAND, PLEASE DISCUSS THIS STATEMENT WITH OUR STAFF BEFORE SIGNING.

I certify that I have read understand and provided the above information to the best of my knowledge. I have answered the questions above as accurately as possible. I understand that providing incorrect information can be dangerous to my child's health. I understand it is my responsibility to inform the dental office of any changes in my child's medical status. I authorize Dr. Derek Tom, Dr. Lauren Imai and staff to gather clinical information, diagnose and perform treatment necessary for my child's dental health care needs.

Signature of Parent/Guardian _____ Date _____ Provider _____



Patient Information

Patient Name: _____
Last First MI
Age: _____ Birth Date: _____ Gender: _____ SS#: _____ Home Phone #: _____
Child resides with: _____ Relation to Patient: _____
Whom may we thank for referring you to our office? _____
Person to contact in case of emergency: _____ Phone: _____

Parent Information

Father/Guardian Name: _____ Birth Date: _____
Last First MI
Address: _____
Street City State ZIP
SS#: _____ Employer: _____ Work Phone: _____
Home Phone: _____ Cellular Phone: _____ E-Mail: _____
Marital Status: Married Single Separated Widowed

Mother/Guardian Name: _____ Birth Date: _____
Last First MI
Address: _____
Street City State ZIP
SS#: _____ Employer: _____ Work Phone: _____
Home Phone: _____ Cellular Phone: _____ E-Mail: _____
Marital Status: Married Single Separated Widowed

Military Personnel Only Rank: E4 and below E5 and above

Dental Insurance Information

Type of Insurance: _____
Subscriber's Name: _____ Subscriber's SS#: _____
Subscriber's Birth Date: _____ Relationship to Patient: _____
Subscriber's No.: _____ Group No.: _____

Secondary Insurance

Type of Insurance: _____
Subscriber's Name: _____ Subscriber's SS#: _____ Subscriber's Birth Date: _____
Relationship to Patient: _____ Subscriber's No.: _____ Group No.: _____

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IT IS UNDERSTOOD THAT THE PATIENT/PARENT ASSUMES FULL RESPONSIBILITY FOR THE TOTAL AMOUNT DUE FOR ALL DENTAL SERVICES REGARDLESS OF INSURANCE COVERAGE.

I certify that I have completed the above information to the best of my knowledge. I understand that although Aiea Pediatric Dental Center may be a participating provider of my dental plan, it is my responsibility to keep this office informed of changes or termination of my dental plan.

I hereby authorize payment of dental benefits otherwise payable to me by my dental insurance plan to be paid directly to Dr. Derek Tom or Dr. Lauren Imai. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for payment of all services rendered on my child's behalf.

I acknowledge and understand by signing below, I have been informed of and offered a copy of Aiea Pediatric Dental Center's 'Notice of Privacy Practices'. I understand that unless I inform Aiea Pediatric Dental Center office of restrictions regarding disclosure of 'Protected Health Information' disclosure will be at their discretion in accordance with the Health Insurance Portability and Accountability Act of 1996.

If I request restrictions I understand my dental insurance company may deny benefits and I will be responsible for the entire balance for all services rendered.

Signature of Parent _____ Date _____