



Remolina Dental Inc.

Welcome!

Thank you for selecting our dental healthcare team! We will strive to provide you with the best possible dental care. Please fill out this form completely.

Patient Information

Date Child's Name First Name Initial Last Name Nickname

Gender Age Birthdate Home Phone

Mailing Address Street City State Zip

Mother Work Ph Cell

DOB Occupation Email address

Father Work Ph Cell

DOB Occupation Email address

Guardian Relationship Phone

DOB Occupation Email address

Name and ages of siblings:

How did you hear about us?

Reason for today's appointment?

INSURANCE INFORMATION

Primary Insurance Plan Secondary Insurance ? Yes No

AUTHORIZATION AND RELEASE

I authorize Remolina Dental to transmit patient information relating to my child's treatment, health or payment by email, mail or electronic filing or other means, without encryption or special security precaution, to me or someone I designate or other health care providers, health plans and others involved in the treatment of my child, payment for treatment or Remolina Dental health care operations. The patient information that may be emailed may include x-rays, health history, diagnosis, treatment and payment records by your authorization.

I understand that my dental insurance carrier may pay less than the actual bill for services.

I agree to be responsible for payment of all services rendered for my dependents.

Payment is due in full at time of treatment unless prior arrangement have been approved.

Signature of Person Responsible for Account

Print Name Relationship Date

Child's Name _____

Physician's Name _____ Phone Number _____ City _____

Although dental personnel primarily treat the area in and around the mouth, the mouth is a part of the entire body. Health problems or medications could have an important interrelationship with the dentistry your child will receive. Thank you for your complete answers for the following questions.

Date of last appointment _____ Reason for appointment _____

Is child taking any medications? Yes No _____

Is child under a physician's specific care now? Yes No _____

Ever been hospitalized or had a major surgery? Yes No _____

Any congenital disorders? Yes No _____

Explain: _____

Is your child allergic to any of the following? Aspirin Penicillin Codeine Latex Milk
 Sulfas Amoxicillin Other allergies _____

Please check all that apply

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> AIDS/HIV Positive | <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> Anemia | <input type="checkbox"/> Asthma | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Brain Injury | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Bruise Easily | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Convulsions/Epilepsy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Digestive Problems | <input type="checkbox"/> Down's Synd. |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Heart Problems | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> Skin Problems | <input type="checkbox"/> Special Needs | <input type="checkbox"/> Use Tobacco |

Additional information _____

Previous Dentist _____ Phone _____ City _____

Date _____ Reason for appointment _____

Please check all that apply

- | | | |
|--|---|---|
| <input type="checkbox"/> Child is complaining of dental problems | <input type="checkbox"/> Injuries to the teeth, mouth or face | <input type="checkbox"/> Breast feeds |
| <input type="checkbox"/> Drinks from baby bottle | <input type="checkbox"/> Drinks from sippy cup | <input type="checkbox"/> Drinks from open cup |
| <input type="checkbox"/> You are happy with child's teeth | <input type="checkbox"/> Child brushes teeth daily | <input type="checkbox"/> Child flosses daily |
| <input type="checkbox"/> Child has had unhappy dental experience | <input type="checkbox"/> Fluoride rinse | <input type="checkbox"/> Fluoride tooth paste |

Check habits that your child has: Pacifier Nail biting Thumb sucking Sleeps with bottle

Comments _____

To the best of my knowledge the questions on this form have been accurately answered. I understand that this information will be used to help determine appropriate and healthful dental treatment. It is my responsibility to inform Remolina Dental of any changes in medical status.

I authorize Dr. Warren to perform the necessary exam, x-rays as needed for diagnosis and cleaning.

Signature _____ Print _____ Relationship _____

Reviewed by Dr. : _____