**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***_______________________________________________ Nickname________________
First Name Initial Last Name

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***

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

Additional information__________________________________________________________________________________

_________________________________________________________________________________________________

***Previous Dentist***________________________________________ Phone ________________ City _________________________

Date _______________ Reason for appointment_____________________________________________________________

***Please check all that apply***

| | | |
|---|---|---|
| ☐ Child is complaining of dental problems | ☐ Injuries to the teeth, mouth or face | ☐ Breast feeds |
| ☐ Drinks from baby bottle | ☐ Drinks from sippy cup | ☐ Drinks from open cup |
| ☐ You are happy with child's teeth | ☐ Child brushes teeth daily | ☐ Child flosses daily |
| ☐ Child has had unhappy dental experience | ☐ Fluoride rinse | ☐ 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. :_________________________