CENTER FOR PEDIATRIC DENTISTRY

2250 W. Whittier Blvd. #200
La Habra, CA 90631
(562) 690-3750

15944 Los Serranos C.C. Dr. #100
Chino Hills, CA 91709
(909) 393-3311

Patient Registration Form

Personal Information

Patient's Name: ______________________________
First Last

Nickname Preferred: __________________________

Gender: Male or Female (circle one)

Date of Birth: __________/_______/__________

Referred By: _______________________________

Address/Contact Information

Address: ___________________________________

City: _______________________ Zip: _________

*Home Phone Number: (_____) _____-________

*Cell Phone Number: (_____) _____-_________

*Email Address: _____________________________

** Prior to your next appointment, you will receive a courtesy appointment reminder via email or text message. Simply click to confirm. To OPT OUT of this service, please let us know.*

Mother's Name (or Legal Guardian): ____________________ DOB: ___/___/____ SS#: _____-____-_____

Father's Name (or Legal Guardian): _____________________ DOB: ___/___/____ SS#: _____-____-_____

Person Responsible For Account, if different from above

Guarantor's Name: ____________________________ DOB: ___/___/_____ SS#: ______-____-_____

Address: ____

Phone Number: (___) ______-______________ Alternate Phone Number: (___) _______-_________

Relationship to Patient: __________________

Insurance Information

Primary Insurance Co.: _________________________

Member I.D.#: ______________________________

Group #: __________________________________

Name of Policy Holder: ________________________

Employer: __________________________________

Secondary Insurance Co.: ___________________

Member I.D.#: ____________________________

Group #: ________________________________

Name of Policy Holder: _____________________

Employer: ________________________________

I give permission to Dr. Kawada and any Associates and Team Members to perform emergency and/or routine diagnostic procedures, including the necessary use of x-rays, to clean my child's teeth, and to apply fluoride to them. I understand that no further treatment will be provided until I am given and consent to a plan of treatment that describes the dental procedures recommended for my child.

Parent/Legal Guardian: ____ **Date:** ______________

Financial Information: As a courtesy, this office will bill your insurance carrier according to the information you have provided above. However, please remember that you are ultimately responsible for payment of all charges unless this is contrary to the terms of your health policy or contract. Our Financial Coordinator will be pleased to answer any questions that you may have.

I have been given a copy of this office's Health Information Privacy Policy and Procedures document. ____________ (initial)
I have been given a copy of California's Dental Material Fact Sheet ("DMFS"). ___________ (initial)

Medical & Dental History Form

Name ____ ____ M F ____/____/_______ Date ___________________
(FIRST) (LAST) (AGE) (SEX) (DOB)

Pediatrician/Physician's Name:_____________________________

Address: ____

____

Phone: ____

Date of last physical examination: ___________________________

Previous Dentist's Name: _________________________________

Address: ____

____

Phone: ____

Date of last dental visit: ___________________________________

Medical History

Please check the appropriate answers YES NO

Is your child under active medical care at this time?................... ☐ ☐
Is your child taking medication now?.. ☐ ☐
If so, for what condition(s)? _________________________________
Please list medication(s): ___________________________________
____
Has your child ever been hospitalized?...................................... ☐ ☐
Has your child ever had a serious illness or operation?.............. ☐ ☐
If so, explain: ____

Does your child have a history of any of the following?

1. Rheumatic fever or rheumatic heart disease.......................... ☐ ☐
2. Congenital heart disease... ☐ ☐
3. Heart murmur... ☐ ☐
4. Measles, mumps, chicken pox, or scarlet fever.................... ☐ ☐
5. Asthma.. ☐ ☐
6. Epilepsy or seizures.. ☐ ☐
7. Hepatitis or liver disease... ☐ ☐
8. Diabetes.. ☐ ☐
9. Juvenile Rheumatoid Arthritis... ☐ ☐
10. Ear tubes or chronic ear infections.. ☐ ☐
11. Kidney disease... ☐ ☐
12. Tuberculosis (TB)... ☐ ☐
13. Sickle Cell disease or trait... ☐ ☐
14. AIDS/HIV infection... ☐ ☐
15. Psychiatric treatment... ☐ ☐
16. Cancer, leukemia, or other tumor... ☐ ☐
17. Birth defect or genetic disorder.. ☐ ☐
18. Growth problems.. ☐ ☐
19. Cerebral palsy.. ☐ ☐
20. Developmental disabilities... ☐ ☐
    If yes, please explain: _________________________________
21. Eating disorders... ☐ ☐
22. Anxiety related disorders... ☐ ☐
23. Autism Spectrum disorders.. ☐ ☐

Is he/she allergic to, or has adversely reacted to, any of the following?

1. Local anesthetics.. ☐ ☐
2. Penicillin or other antibiotics... ☐ ☐
3. Sulfa drugs... ☐ ☐
4. Latex products.. ☐ ☐
5. Food products... ☐ ☐
6. Others: ____

ADOLESCENT WOMEN:
Are you pregnant now, or think you may be?.............................. ☐ ☐
Are you taking oral contraceptives?... ☐ ☐

Dental History

Please check the appropriate answers YES NO

Has he/she had any serious problem(s) associated with any previous dental treatment?.. ☐ ☐
If so, please describe:_____________________________________
____
Date of last dental x-rays: __________________________________
Has he/she ever had orthodontic treatment?................................ ☐ ☐
Do his/her gums bleed when brushing teeth?............................. ☐ ☐
Has he/she often had toothaches?... ☐ ☐
Has he/she had frequent sores in his/her mouth?........................ ☐ ☐
Has he/she had any injuries to his/her mouth or jaws?................ ☐ ☐
Are you satisfied with your child's previous dental care?............ ☐ ☐
Does your child have a history of thumbsucking?....................... ☐ ☐
Does your child have a disability that prevents treatment in an outpatient dental office?... ☐ ☐

Is there anything else that you would like us to know about your child which may be helpful to his dental experience? __________________
____
____
____

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has a change in his/her health or his/her medication, I will inform the doctor at the next appointment without fail.

X____

Parent/Legal Guardian Signature **Date**

Notes: ____
____
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