Welcome !

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions, we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date ______________

Name of Minor/Child ____
Last Name / First Name / Initial

Nickname __________ Sex ☐ M ☐ F Age ______ Birthdate __________ Soc. Sec. # ______________

Home Address ____
Street / City / State / Zip

Mailing Address ____
Street / City / State / Zip

Person financially responsible ______________ Home Phone __________ Work Phone __________

Whom may we thank for referring you ? ______________________________

INSURANCE

Father's / Guardian's Name ______________________

Address (if different from patient's) ______________________

Home Phone __________ (if different from above) Work Phone __________ (if different from above)

Employer ______________________

Soc. Sec. # __________ Birthdate __________

Do you have dental insurance coverage for minor/child ? ☐ Yes ☐ No

Plan Name ______________________

Phone No. ______________________

Address ______________________

Group # ______________________

Policy # ______________________

Mother's / Guardian's Name ______________________

Address (if different from patient's) ______________________

Home Phone __________ (if different from above) Work Phone __________ (if different from above)

Employer ______________________

Soc. Sec. # __________ Birthdate __________

Do you have dental insurance coverage for minor/child ? ☐ Yes ☐ No

Plan Name ______________________

Phone No. ______________________

Address ______________________

Group # ______________________

Policy # ______________________

Anna Witanto D.D.S. 33137 Alvarado Niles Road, Union City, CA 94587 (510) 489-6900

Please Complete Both Pages

DENTAL HISTORY

Date of last visit to a dentist ______________ For what service? ______________

	YES	NO		YES	NO
Has child complained about dental problems ?	☐	☐	Is fluoride taken in any form ?	☐	☐
Does child brush teeth daily ?	☐	☐	Any injuries to mouth, teeth, head ?	☐	☐
Does child use floss every day ?	☐	☐	Any unhappy dental experiences ?	☐	☐
Any mouth habits – thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc. ?				☐	☐

MEDICAL HISTORY

Minor/Child's Physician ______________ City/State ______________ Phone ______________

Date of last physical examination ______________ Results ______________

	YES	NO	
Is Minor/Child under care of physician now?	☐	☐	Medications ______________
Receiving any medication or drugs?	☐	☐	______________
Ever been hospitalized?	☐	☐	______________
Ever had surgery?	☐	☐	Allergies ______________
Is there excessive bleeding when cut?	☐	☐	______________

Has Minor/Child had any history of or difficulty with any of the following? If YES, Please check (☐)

☐ AIDS / HIV	☐ Chicken Pox	☐ Heart Problems	☐ Mumps
☐ Anemia	☐ Convulsions	☐ Hepatitis	☐ Rheumatic Fever
☐ Asthma	☐ Diabetes	☐ Kidney Disease	☐ Sinus Problems
☐ Bladder Problems	☐ Drug/Alcohol Abuse	☐ Liver Disease	☐ Thyroid Disease
☐ Cancer	☐ Fainting	☐ Measles	☐ Tuberculosis
☐ Cerebral Palsy	☐ Hearing Problems	☐ Mononucleosis	☐ Other

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name ______________ Relationship ______________ Phone ______________

Name ______________ Relationship ______________ Phone ______________

AUTHORIZATION

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I acknowledge HIPAA and grant permission to Dr. Anna Witanto, D.D.S. and staff to release any necessary records to specialist, insurance, or anyone who will assist with the dental treatment. I acknowledge that I have received a copy of the Dental Materials Fact Sheet dated 10/2001. I authorize the dental staff to perform the necessary dental services for my minor/child.

Signature of Parent/Guardian ______________ Date ______________

I certify that my minor/child is covered by insurance with ______________
Name of Insurance Company(ies)

and assign directly to **Dr. Anna Witanto** all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I am also, aware that an unpaid balance over 90 days will be charged a 1% finance charge. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent/Guardian ______________ Date ______________