Welcome

Walnut Creek Kids Dentistry
Dr. Duane Spencer, Dr. Jason Renner, &
Dr. Don Do
1844 San Miguel Dr., Suite 112
Walnut Creek, CA 94596
Phone: 925-937-4030

Health History Form

Today's Date: _____

NOTE: The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1 Tell Us About Your Child

Child's Name _____
Last First MI

Goes by: _____ ☐ Male ☐ Female

Siblings that we treat _____

Child's Birthdate _____/_____/_____ Child's Age _____

School_____Grade_____

Child's Home # (_____)_____

Child's Home Address:_____

_____
City State Zip

Email Address:_____

☐ I accept emails are for appointment confirmations and communication only. I am aware I can remove my email at anytime.

2 Who may we thank for referring you to our office?

_____

3 Parent's Information

Name _____

Birthdate ___/___/____ ☐ Mother/Father ☐ Stepparent ☐ Guardian

Employer _____Occupation_____

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

4 Parent's Information

Name _____

Birthdate ___/___/____ ☐ Mother/Father ☐ Stepparent ☐ Guardian

Employer _____Occupation_____

Work # (_____)_____ Ext. _____

Home # (_____)_____

Cellular Phone # (_____)_____

SS # _____ DL# _____

5 Who is Accompanying the Child Today?

Name _____

Relationship_____

Do you have legal custody of this child? ☐ Yes ☐ No

6 Person Responsible for Account

Name_____

Relationship_____

Billing Address _____

_____
City State Zip

Home # (_____)_____

Work # (_____)_____

Cellular # (_____)_____

E-mail _____

7 Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (_____)_____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____/ _____/ _____

Social Security # _____

Policy Owner's Employer _____

8 Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

_____

Insurance Co. Phone # (_____)_____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient_____

Policy Owner's Birthdate _____/ _____/ _____

Social Security # _____

Policy Owner's Employer _____

9 Dental History

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Previous Dentist's Name_____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain_____

_____

_____

Why did you bring the child to the dentist today? _____

_____

_____

Does the child have any of the following habits?

Y N Lip Sucking / Biting Y N Nail Biting

Y N Nursing / Bottle Habits Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain _____

_____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in his/her jaw/ joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

10 Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding
Y N Allergies to any Drugs
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Congenital Birth Defects
Y N Convulsions/Epilepsy
Y N Pregnancy
Y N Tuberculosis
Y N ADD/ADHD

Y N Disabilities/Special Needs
Y N Hearing Impairment
Y N Heart Disease/Murmur
Y N Hemophilia/Blood Disorders
Y N Hepatitis
Y N HIV + / AIDS
Y N Kidney/Liver Conditions
Y N Rheumatic/Scarlet Fever
Y N Allergies to Latex Product
Y N Diabetes
Y N Autism

Please discuss any serious medical conditions the child has had

_____

_____

Please list all drugs the child is currently taking_____

_____

Please list all allergies_____

_____

Child's Physician _____

Phone (_____)_____

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health...

Good **Fair** **Poor**

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

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I understand that the information I have given is correct to the best of my knowledge, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____ _____

Signature of Parent or Guardian Date Relationship to Patient

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Dental Insurance: The doctors recommend dental treatment for patients not knowing if the parent has dental insurance. Please understand that if you have dental insurance, it is your policy. Our office will attempt to give you the best estimate according to your insurance and we will bill your insurance for you. It is your responsibility to pay any deductible amount, co-insurance, or any other balance not paid by your insurance company. By signing, you understand our policy and you give authorization to release necessary information to process claims on your behalf payable to our doctors.

_____ _____ _____

Signature of Parent or Guardian Date Relationship to Patient

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I acknowledge that a copy of this office's **Notice of Privacy Practices** has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

_____ _____ _____

Signature of Parent or Guardian Date Relationship to Patient