Salinas Valley
Dental Specialties

Child´s Name _____ Nickname _____ Sex (F) (M) Birthdate _____
First Middle Last

Father (full name) _____ SSN _____ Birthdate _____ Phone _____

Mother (full name) _____ SSN Birthdate _____ Phone _____

Married ☐ Divorced ☐ Child resides with: _____

Home address _____ Phone _____
Street City Zip

Email Address _____ Person financially responsible for child´s dental care _____

Does your child have any special needs? _____

Who may we thank for referring you to us? _____

Health History

Who has legal rights to make health care decisions for this patient: Mother ☐ Father ☐ Both ☐

_____

Child´s Pediatrician _____ Phone number _____

Is your child under a physician´s care now? _____ Reason _____

Is your child taking any medication? _____ What Kind _____ Reason _____

Has your child ever been hospitalized? _____ Reason _____

Is your child allergic to any medications? _____ Please list _____

Does your child has any of these habits: finger/thumb sucking ____ pacifier ____ lip sucking ____ mouth breathing ____ snoring ____ teeth grinding ____

Has your child had any injuries to teeth, mouth or head? _____ Describe _____

Has your child had a history or difficulty with any of the following:

YES	NO		YES	NO		YES	NO		YES	NO	
____	____	Premature Birth	____	____	Earaches	____	____	Speech Disorder	____	____	Nosebleeds
____	____	Heart	____	____	Kidney	____	____	Hearing	____	____	Asthma
____	____	Seizures	____	____	Bleeding	____	____	Brain injury	____	____	Liver
____	____	Immune disorder	____	____	Cerebral Palsy	____	____	Bruising	____	____	Bone disorder
____	____	Allergy to medication	____	____	Anemia	____	____	Bladder	____	____	Rheumatic fever
____	____	Diabetes	____	____	Motion sickness	____	____	Fainting or dizziness	____	____	Cancer or malignancies
____	____	Hepatitis	____	____	Delayed Development	____	____	Emotional or school problems	____	____	Tuberculosis
____	____	Autism	____	____	ADD/ADHD	____	____	Any medical condition not on this form			

Do you have dental insurance coverage for your child? _____

Father´s insurance company _____ Group No. _____

Mother´s insurance company _____ Group No. _____

Address of insurance company _____ Zip _____

I hereby authrize payment to the above named dentist of the group dental benefits, otherwise payable to me but not to exceed the charges shown on the claim. I understand I am financially responsible for any charges not covered by my insurance or by this authorization.

Signature _____ Relationship _____ Date _____