THOUSAND OAKS CHILDREN'S DENTISTRY, P.A.

NEW PATIENT INFORMATION

Date_____

Patient_____ Age_____ Birthday_____

Name your child would like to be called_____ Sex: Male__ Female__

Home address_____ Phone_____
Cell _____

City, State, Zip_____

School_____ Grade_____

Name and ages of other children_____

Mother_____ SS#_____

Mother's Employer_____ Phone_____

Father_____ SS#_____

Father's Employer_____ Phone_____

Who has legal custody of patient?_____

Person responsible for payment of account/driver's license #_____

Dental insurance___Yes ___No Please specify:_____

Whom may we thank for referring you to our office?_____

What is the reason for your child's dental visit?_____

HEALTH HISTORY

Yes	No	
__	__	Is your child in good health? Name/phone of child's physician_____
__	__	Has your child ever been hospitalized? Please give reason and date_____
__	__	Is your child allergic to anything (medications, food, skin, etc.)?_____
__	__	Is your child currently taking any medications? Please give medication and reason
__	__	Has your child ever had a health problem?_____

Please *circle* if your child has been treated for any of the following:

Heart disease	Bleeding/Transfusions	Asthma	Liver disease
Hepatitis	Kidney disease	Seizures	Rheumatic fever
Anemia	Speech/Hearing	Diabetes	Cleft lip/palate
HIV/AIDS	Cerebral Palsy	Other problems	

Please elaborate_____
_____

DENTAL HISTORY

Was your child breast fed_____ Bottle fed_____ At what age was it stopped_____

Yes	No	
—	—	Has your child ever been to the dentist? Name of the dentist and date_____ _____
—	—	Has your child experienced any unfavorable reaction from previous dental care? Please explain_____
—	—	Does your child suck a finger, thumb, or pacifier?
—	—	Does your child grind his/her teeth?
—	—	Does your child suck/bite on his/her lips or cheeks?
—	—	Is your child taking a fluoride supplement? Please explain_____

Is there any additional information we should know that will help us provide a positive dental experience for you child?_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

Signed_____Relationship_____Date_____

THOUSAND OAKS CHILDREN'S DENTISTRY, P.A.

CONSENT FOR DENTAL PROCEDURE(S) AND ACKNOWLEDGMENT OF RECEIPT OF INFORMATION

State law requires us to obtain your consent for your child's contemplated dental treatment and/or oral surgery. Please read this form carefully and ask us anything that you do not understand. We will be pleased to explain it. Dr. Doose also requires that a parent/guardian remain in the office for the duration of the child's treatment.

1. I hereby authorized and direct Dr. Doose, and any employees under his supervision, to perform upon my child (legal ward) any and all manner of dental treatment that may be indicated.

2. In general terms, the dental procedure(s) will include:

✓ Diagnostic examination

✓ Cleaning of the teeth and the application of topical fluoride

✓ Dental X-rays

____ Application of sealants (protective coatings) to the grooves of the teeth

____ Administration of local anesthetic(s)

____ Administration of Nitrous Oxide

____ Treatment of diseased or injured teeth with dental restorations

____ Treatment of diseased or injured oral tissue (hard or soft)

____ Removal (extraction) of one or more teeth

____ Replacement of missing teeth with dental prosthesis

____ Treatment of malposed (crooked) teeth and/or oral developmental/growth abnormalities

____ Other_____

3. Although the occurrence is extremely remote, some risk are known to be associated with dental treatment and/or oral surgery procedures including anesthesia. State law requires us to mention the risk of numbness (partial or complete/ temporary or permanent), infection, sensitivity, swelling, bleeding, discoloration (bruising), nausea, vomiting, allergic reactions, jaw fracture, and/or damage to adjacent teeth.

4. The risk and the nature of the treatment have been explained to me. Alternative methods of treatment, if any, have also been explained to me, as have the advantages and disadvantages of each. I am advised that, though good results are expected, the possibility and nature of complications cannot be accurately anticipated and therefore, no guarantee has been made as to the result of the treatment or cure. I further authorize Dr. Doose to perform other dental services that, in his judgment, are advisable for my child or legal ward, with the exception of (if none so state):_____

_____

I further understand that this consent will remain in effect until such time I choose to terminate it.

Patients Name_____ Date_____

Signature of Parent/Guardian_____Relationship_____