



Welcome to Ortiz Dental Care

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!

Patient Information:

Date: _____

Child's Name: _____

_____ First Last

Date of Birth ____/____/____

Address: _____

Street

Apt

City

State

Zip Code

Mother Name : _____ Cell () _____

Father' Name _____ Cell () _____

Email : _____ How did you hear of us ? _____

Who is accompanying the child today ? _____

Insurance Information :

Name of the insurance _____ ID # _____

Important

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

Signature _____

Date: _____



Dental & Medical History :

Child's Physician: _____ Date of last Visit: _____

Is the child currently in pain ? _____

Does the child require antibiotics before dental treatment ? _____

Does the child had any surgery ? _____

Has the child been hospitalized? _____

Has the child experienced any medical problems? _____

Is the child allergic of any medications ? _____

Has the child experienced the following medical problems?

- | | | | | | |
|----------------------------|----------------------------|--------|----------------------------|----------------------------|--------------|
| <input type="checkbox"/> Y | <input type="checkbox"/> N | HIV | <input type="checkbox"/> Y | <input type="checkbox"/> N | Measles |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Anemia | <input type="checkbox"/> Y | <input type="checkbox"/> N | Diabetes |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Asthma | <input type="checkbox"/> Y | <input type="checkbox"/> N | Heart Murmur |
| <input type="checkbox"/> Y | <input type="checkbox"/> N | Cancer | <input type="checkbox"/> Y | <input type="checkbox"/> N | Autism |

Dental History:

Previous / Present Dentist: _____ Date of the last visit _____

Has the child ever had a serious / difficult problems associated with previous dental work ?

Does the child have any Habits ? _____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence 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 Guard

Date

