hersch
PEDIATRIC DENTISTRY AND ORTHODONTICS

400 Newport Center Dr., Ste. 701
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P 949.644.0611 F 949.644.1334

Geoffrey M. Hersch, D.D.S., APC | Pediatric Dentistry
Leslie Butler, D.D.S., Inc. | Pediatric Dentistry
William H. Harrison, D.D.S. | Orthodontics

Tell Us About Your Child

Today's Date:_____ Child's Home Phone#: (_____)_____ Social Security #: _____

Child's Name: _____ Child's Birthdate: _____ / _____ / _____ Child's Age: _____
Last First MI

Nickname: _____ ☐ Male ☐ Female School: _____ Grade: _____

Child's Home Address: _____
Street City State Zip

Who may we thank for referring you? _____

What is the primary reason for today's visit?_____

Is your child adopted? ☐ Yes ☐ No Has any member of your family been or is currently a patient in this office? ☐ Yes ☐ No

If yes, name: _____

Dental History

Is your child currently in pain? _____ ☐ Yes ☐ No Is this your childs first dental visit? ☐ Yes ☐ No

Has your child experienced problems with previous dental work? ☐ Yes ☐ No If so, explain: _____

Previous Dentist: _____ Date of Last Visit: _____ Date of Last X-Ray: _____

Why did you leave your previous dentist? _____

What did you like most about any dentist you have seen? _____ Least? _____

Have there been any injuries to your child's teeth jaws, falls, blows, chips, etc. ☐ Yes ☐ No
Does your child take fluoride vitamins or drink fluoridated water? ☐ Yes ☐ No
Has your child been seen by an orthodontist? ☐ Yes ☐ No Who? _____
Does your child brush his / her teeth daily? ☐ Yes ☐ No Does he / she require parental help? ☐ Yes ☐ No
Does your child floss his / her teeth daily? ☐ Yes ☐ No Does he / she require parental help? ☐ Yes ☐ No

Name of Parent's dentist: _____ City: _____ Phone: (_____)_____

Does / did your child have any of the following habits? (please circle)

Y N lip sucking and nail biting	**Y N** chewing on objects	**Y N** TMJ / TMD pain	**Y N** clenching / grinding teeth
Y N thumb / finger sucking	**Y N** nursing bottle habits	**Y N** tongue / cheek biting	**Y N** used pacifier
Y N tongue thrust	**Y N** mouth breather	**Y N** speech problems	**Y N** breast fed

Medical History

Child's Physician:_____ Phone: (_____)_____ Date of last visit: _____

Address:_____

Is your child currently under the care of a physician? ☐ Yes ☐ No Please explain: _____

Does your child have social/personality/temperament concerns that we should be aware of? _____

Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor **Are Immunizations Current?** ☐ Yes ☐ No

Please list all medications and dosage that your child is currently taking: _____

Please list all drugs and / or things that cause your child allergic reactions: _____

Anything you would like to discuss with the Doctor in Private? ☐ Yes ☐ No

Has your child had / experienced any of the following: (please circle)

Y N Abnormal Bleeding	**Y N** Diabetes	**Y N** Low Blood Pressure
Y N AIDS / HIV +	**Y N** Endocrine System Disorders	**Y N** Lupus
Y N Allergies	**Y N** Epilepsy	**Y N** Measles
Y N Anemia	**Y N** Frequent Infections	**Y N** Mitral Valve Prolapse
Y N Any Hospital Stays	**Y N** Handicaps	**Y N** Mononucleosis
Y N Any Operations	**Y N** Behavior / Learning / Disabilities	**Y N** Recurrent Headaches / Frequency
Y N Asthma	**Y N** Mentally / Physically Disabled	**Y N** Rheumatic Fever
Y N Autism	**Y N** Hearing Impaired	**Y N** Seizures
Y N Blood Dyscrasis	**Y N** Heart Murmur	**Y N** Scarlet Fever
Y N Blood Transfusion/Date	**Y N** Hemophilia	**Y N** Sickle Cell Anemia
Y N Breathing / Lung Problems	**Y N** Hepatitis	**Y N** Sight Disorders
Y N Cancer / Tumors	**Y N** High Blood Pressure	**Y N** Significant Injuries/ What
Y N Chicken Pox	**Y N** Hives	**Y N** Skin Rash
Y N Congenital Birth Defect	**Y N** Kidney Problems	**Y N** Tonsilitis
Y N Congenital Heart Defect	**Y N** Liver / GI System Problems	**Y N** Tuberculosis (TB)

Please discuss any serious medical problems your child experiences, now or in the past: _____

_____

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Parents Information

Family's E- Mail: ______________________ Parent's Marital Status: ☐ Married ☐ Single

Father / Step Birthdate: ____ / ____/ ____ Home Phone #: (______)______________ Work Phone #: (______)______________

Name: ______________________ Social Security #: ______________________ Drivers License #: ______________________

Address: ____
Street City State Zip

Employer: ______________________ Occupation: ______________________ Length of Employment: ________

Employers Address: ____
Street City State Zip

Father / Step Cell #: (______)______________________ Mother / Step Cell #: (______)______________________

Mother / Step Birthdate: ____ / ____/ ____ Home Phone #: (______)______________ Work Phone #: (______)______________

Name: ______________________ Social Security #: ______________________ Drivers License #: ______________________

Address: ____
Street City State Zip

Employer: ______________________ Occupation: ______________________ Length of Employment: ________

Employers Address: ____
Street City State Zip

Name of parent who resides with the child: ____

Nearest relative: ______________________ Address: ______________________ Phone: ______________

Is your child covered by a dental insurance plan? ☐ Yes ☐ No

Insurance Information

Primary Insurance

Insurance Co. Name: ______________________ Phone #: (____)______________ Group # (Plan, Local, or Policy#): ______________

Insurance Co. Address: ____
PO Box / Street City State

Insured's Name: ______________________ Relationship to Patient: ______________________

Insured's Address (if different from above): ______________________ Home Phone #: (____)______________

Insured's Birthdate: ____ / ____/ ____ Social Security #: ______________ Insured's Employer: ______________________

Secondary Insurance

Insurance Co. Name: ______________________ Phone #: (____)______________ Group # (Plan, Local, or Policy#): ______________

Insurance Co. Address: ____
PO Box / Street City State

Insured's Name: ______________________ Relationship to Patient: ______________________

Insured's Address (if different from above): ______________________ Home Phone #: (____)______________

Insured's Birthdate: ____ / ____/ ____ Social Security #: ______________ Insured's Employer: ______________________

Financial Responsibility

I assume financial responsibility for all dental treatment and medications provided for my child, and understand that payment is expected on the date services are provided. I request and authorize my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I therefore am ultimately responsible for payment of services rendered on my behalf or my dependents.

Signature ______________________ Date ____________

Authorization and Release

To the best of my knowledge the information I have given on this form is correct, and 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. I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payors and / or their health practitioners.

I have received a copy of this office's Notice of Privacy Practices. I consent to their use and disclosure of my children(s) Protected Health Information to carry out treatment, payment activities and healthcare operations.

Signature ______________________ Date ____________

Medical history review: ___/___/___ /___/___/___/___/___/___/___/___/___/___/___/___/___/___/___/___/___/___/___