Children's Dental Associates, Inc.

1314 South King Street, Suite 618
Honolulu, Hawaii 96814
Telephone: (808) 596-9889

94-673 Kupuohi Street, Suite #C103
Waipahu, Hawaii 96797
Telephone: (808) 680-0097

Please Print

Child's Information

Child's Name: ______________________ Nickname: __________
Last First M.I.

Social Security Number: __________ Birth Date: __________ Sex: M or F

Address: ______________________
Street Apt. #

____
City State Zipcode

Phone Number: ( ) __________

Mother's Name: ______________________ Birth Date: __________
(or Legal Guardian)

Marital Status: □ Single □ Married □ Divorced Social Security No.: __________

Home Address (If different from above): ______________________
Street Apt. #

____
City State Zipcode

Occupation: __________ Employer: __________

Place of Employment: ______________________
Street

____
City State Zipcode

Home Phone: __________ Work Phone: __________ Cell Phone: __________

Father's Name: ______________________ Birth Date: __________
(or Legal Guardian)

Marital Status: □ Single □ Married □ Divorced Social Security No.: __________

Home Address (If different from above): ______________________
Street Apt. #

____
City State Zipcode

Occupation: __________ Employer: __________

Place of Employment: ______________________
Street

____
City State Zipcode

Home Phone: __________ Work Phone: __________ Cell Phone: __________

Emergency Contact Person: __________ Relationship: __________ Phone: __________

Child's Previous Dentist: __________ Phone: __________

Address: ______________________
Street

____
City State Zipcode

Medical History

1. Were there any difficulties during this pregnancy, delivery, or first year of the child's life? | Yes | No |

   If so, for what reason: ____________________

2. Was your child premature? | Yes | No |

   If so, for what reason: ____________________

3. Is a doctor treating your child now for a specific illness or condition? | Yes | No |

   If so, for what reason: ____________________

4. Is your child taking any medication at this time? (If yes, please list below) | Yes | No |

Medication	Dose/Frequency	Reason

5. Has your child taken any unusual medication in the past? | Yes | No |

   If so, what and for what reason: ____________________

6. Has your child shown any allergies or unusual reactions to any of the following: | Yes | No |

   a. Medications or drugs: ____________________

   b. Foods: ____________________

   c. Latex, Rubber: ____________________

   d. Other: ____________________

7. Has your child ever been admitted to a hospital or needed emergency care during the past two years? | Yes | No |

   When, and for what reason: ____________________

8. Has your child ever had an operation? | Yes | No |

   When, and for what reason: ____________________

   Was general anesthesia used?
   If so, what:

   Were there any complications?
   If so, what:

9. Are all your child's immunizations up to date? | Yes | No |

DPT/date of last booster	________	Hep B/date of last booster	________
Polio (all 3 oral doses)	________	Sickle Cell Test	________
Measles, Mumps, Rubella	________	Tuberculin (TB) test	________
Chicken Pox	________	HIB	________
Tetanus	________		

10. Does your child have any history of the following diseases or conditions? (Select all that apply) | Yes | No |

- □ Rheumatic Fever
- □ Heart Disease
- □ Immune Deficiency
- □ Diabetes
- □ Asthma
- □ Tuberculosis
- □ Seizures
- □ Jaundice
- □ Liver Disease
- □ Sickle Cell Disease/Trait
- □ Cystic Fibrosis
- □ Bleeding Problems
- □ Anemia
- □ Hepatitis
- □ Leukemia or Tumors
- □ Kidney Disease
- □ Pregnancy: ______ (Months)
- □ Heart murmur: ____________________
- □ Learning disabilities: ____________________
- □ Emotional disabilities: ____________________
- □ Hearing difficulty: ____________________
- □ Speech difficulty: ____________________

11. Does your child bruise easily? | Yes | No |

    if so, please explain:

Medical History, cont.

12. Has there ever been any history of spontaneous bleeding (e.g., nose bleeds or prolonged bleeding following tooth removal, surgery, cuts, etc.? | Yes | No |

    If so, please explain

13. What is the name of your child's doctor or pediatrician? ______________________

14. Does your child have any health problems that need further clarification? | Yes | No |
    If yes, please explain:

Dental History

1. Please check reason(s) for seeking dental care for your child:
   - ☐ First examination
   - ☐ Appearance of teeth or face
   - ☐ Routine check-up
   - ☐ Crowding of teeh
   - ☐ Toothache or swelling
   - ☐ Accident
   - ☐ Other:

2. Has your child been to a dentist previously? | Yes | No |
   a. When was the last visit: ______________________
   b. How did your child react to x-rays or to the dental visit? ______________________
   c. Please describe his/her temperament? ______________________

3. How do you think your child will react to dental treatment in our office?

4. Has your child had fluoride in any of the following forms? | Yes | No |
   - ☐ Fluoride tablets or in multiple vitamins
   - ☐ Drinking water (community fluoride)
   - ☐ Topical application to teeth; last application: ______________
   - ☐ Toothpaste; brand ______________

   Have there been any reactions; if so, please describe:

5. Have your child's teeth ever been injured? | Yes | No |
   When? ______________________
   Which tooth/teeth? ______________________
   Cause? ______________________

6. Does your child have any of the following habits? Indicate ages when occurred: | Yes | No |
   - ☐ Bottle to bed at night or during nap. What was in the bottle? ______________
   - ☐ Thumb or finger sucking ______________
   - ☐ Tongue thrusting ______________
   - ☐ Lip sucking or biting ______________
   - ☐ Mouth breathing ______________

7. Has your child received any unusual dental or surgical treatment to the mouth? | Yes | No |
   If so, what:

8. Has your child ever had any complications during dental treatment? | Yes | No |
   If so, what:

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If my child ever has any changes to his/her health, I will inform the doctors/dentists at the next appointment without fail.

**** Please sign in office in the presence of a staff member ****

______________________________________ ______________

Signature of parent/custodial parent or legal guardian (Circle the applicable description) Date

Referral Information

Whom may we thank for referring you to our practice (i.e., another patient, dental office, yellow pages, work, newspaper, or referral office? ______________________

Responsible Party

Who is responsible for this Patient's account? ______________________

Relationship to the Patient/Child? ______________________

Dental Insurance

Name of the Subscriber: ______________________ Birthdate: ____________

Relationship to the Patient/Child? ______________________

Name of Insurance Plan: ______________ ID #: ____________ Group Plan #: ________

Is Patient covered by additional insurance? ☐ No ☐ Yes If Yes, complete below:

Name of the Subscriber: ______________________ Birthdate: ____________

Relationship to the Patient/Child? ______________________

Name of Insurance Plan: ______________ ID #: ____________ Group Plan #: ________

Assignment and Release

I certify that I (and/or my dependent(s)) have insurance coverage with ______________________
(Name of Insurance company or companies)
and assign directly to Children's Dental Associates, Inc., all insurance benefits and any amount payable to me for services rendered. I understand that I am financially responsible for all charges whether or not payable by insurance. I authorize the use of my signature on all insurance submissions.

The above named dental practice may use my or my minor child's health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end upon receipt of written notification of request to withdraw assignment and release.

**** Please sign in office in the presence of a staff member ****

______________________ ____________
Signature of Parent or Legal Guardian or an Authorized Representative Date

______________________ ____________
Please print Name of Parent or Legal Guardian or Authorized Representative Relationship to Patient

NOTIFICATION OF POLICY ON MISSED APPOINTMENTS:

24 HOUR PRIOR NOTIFICATION IS REQUIRED FOR CANCELLATION OF APPOINTMENTS. CALLS TO CANCEL APPOINTMENTS FOR THE DAY OF THE APPOINTMENT DUE TO ILLNESS IS ALSO REQUIRED. CANCELLATION OF APPOINTMENTS WITH **NO PRIOR NOTIFICATION** WILL BE CONSIDERED "MISSED" APPOINTMENTS. PATIENTS WITH TWO (2) "MISSED" APPOINTMENTS WILL BE DISMISSED FROM THE PRACTICE.

I acknowledge that I have read and understand the above policy.

**** Please sign in office in the presence of a staff member ****

______________________ ____________
Signature of Parent or Legal Guardian or an Authorized Representative Date

Children's Dental Associates, Inc.

1314 S. King Street, Suite 618
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Waipahu, Hawaii 96797

Consent for Services and Financial Arrangements

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursements from the patients for the costs incurred in their care. Financial responsibility by the parent(s)/guardian(s) of each patient must be determined before treatment.

All emergency dental services, of any dental services, performed without previous financial arrangements must be paid for in cash at the time services are performed.

Parent(s)/guardian(s) of patients with dental insurance must understand that all dental services furnished are charged directly to the parent(s)/guardian(s) and that the parent(s)/legal guardian(s)/guarantor is personally responsible for payment of all dental services. This office will help prepare the patient's insurance claim forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, the dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A late charge may apply on all accounts exceeding ninety (90) days, unless previously agreed upon written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of patient examination.

In consideration for the professional services rendered to my child/ward, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing, if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof.

I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further terms or conditions. I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

I grant permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.
**** Please sign in office in the presence of a staff member ****

______________________________	____________	____________
Signature of Parent, Legal Guardian or Authorized Representative	Date	Relationship to Patient
______________________________	____________	____________
Signature of Guarantor of Payment/ Responsible Party	Date	Relationship to Patient