This is a fillable form: *Please download first, then type your information & print.*

San Diego Dental Specialists

Drs. Thurston, Lam, Amodeo
Registration

Child's Name_____
Nick name_____Sex_____
Date of Birth_____Age_____
Child's Address _____
City_____State_____Zip_____
Home Phone#_____
School _____
Child's Favorite Activities_____
Mother's Name_____
Mother's DOB_____
Occupation_____
Father's Name_____
Father's DOB_____
Occupation_____

Responsible Party_____
Home Phone #_____
Cell Phone # _____
Email Address_____
Employer_____
Business Address_____
City_____State_____Zip_____
Business Phone # _____
Driver's License#_____

Have we treated any of your Immediate Family? ◯Y ◯N
Have we treated any of your Relatives ◯Y ◯N Please List_____

Who may we thank for referring you to our practice?_____

Where have you seen or heard about our practice? (please check all that apply)
☐ Pediatrician _____ ☐ Your Dentist _____☐ Community Event _____
☐ Friend/Neighbor_____ ☐ School Sponsorship/Event _____
☐ Our website (www.pdospecialists.com)
☐ Yelp ☐ Facebook ☐ Internet Search ☐ Other_____

If you would like us to assist you in filing your insurance claim please complete the following information. If you are the patient receiving care, your insurance is the primary carrier and your spouse's is the secondary. If the patient is a child (dependent), the primary carrier is the parent whose birth month is closest to the beginning of the year.

Primary Carrier
Name of Insured_____
Social Security # _____
Insurance Carrier_____
Employer _____
Group#_____Union/Local_____
Subscriber#_____
Date of Birth_____
Relationship_____

Secondary Carrier
Name of Insured _____
Social Security # _____
Insurance Carrier _____
Employer _____
Group# _____Union/Local_____
Subscriber#_____
Date of Birth_____
Relationship_____

Emergency Contact Information

Name of Contact_____
Phone Number_____
Relationship_____

Name of Contact_____
Phone Number_____
Relationship_____

I hereby authorize payment of the dental benefits otherwise payable to me directly to the above named entity. I agree to be responsible for all the charges for dental services and materials not paid by my dental benefit plan, unless the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted under applicable law, I authorize release of any information relating to this claim.

_____ _____
Signed (Subscriber/Parent) Date

Registration

Child's Name _____

	MEDICAL HISTORY	yes	no	office use
1.	Does your child have any health problems? …… Please elaborate _____ _____	☐	☐	
2.	My child is under the care of Dr. _____for the following medical condition(s)_____ _____ Telephone _____			
3.	Is your child currently taking any medications or herbal supplements? Medicine _____ Dosage _____ Medicine _____ Dosage _____	☐	☐	
4.	Does or has your child taken diet enhancers……....	☐	☐	
5.	Is your child allergic to any antibiotics, such as amoxicillin, sulfa or other medications?……..…….. Specify antibiotic_____	☐	☐	
6.	Does your child have a history of allergy or sensitivity to any metals (e.g. nickel), latex or any other not mentioned? _____	☐	☐	
7.	Has your child had a serious illness?…….. When_____Type_____	☐	☐	
8.	Has your child ever had surgery or been hospitalized? …….. When_____ Why_____ When_____ Why_____	☐	☐	
9.	Has your child had any heart condition? ……..	☐	☐	
10.	Has your child ever had heart surgery? ……..	☐	☐	
11.	Is your child subject to nervous disorders? …….. ☐ Fainting or Dizziness ☐ Seizures ☐ Behavior/learning difficulties	☐	☐	
	Does your child have frequent headaches? ……..	☐	☐	

12. Has your child had a history of (check appropriate responses):

☐ heart trouble	☐ asthma	☐ cleft lip or palate	☐ cerebral palsy
☐ bleeding problem	☐ diabetes	☐ HIV or AIDS	☐ malignant hyperthermia
☐ clotting problem	☐ seizure	☐ bone pathology	☐ congenital birth defect
☐ artificial joints	☐ arthritis	☐ liver problem	☐ kidney problem
☐ intellectual disability	☐ cancer	☐ hearing loss	☐ eyesight problem
☐ speech impediment	☐ infections	☐ drug dependency	☐other problem not listed

I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

PARENT'S/GUARDIAN'S SIGNATURE_____ DATE_____DENTIST'S SIGNATURE _____

HEALTH HISTORY UPDATE:

_____/_____/_____		_____/_____/_____		_____/_____/_____		_____/_____/_____	
Date	Parent Doctor	Date	Parent Doctor	Date	Parent Doctor	Date	Parent Doctor
_____/_____/_____		_____/_____/_____		_____/_____/_____		_____/_____/_____	
Date	Parent Doctor	Date	Parent Doctor	Date	Parent Doctor	Date	Parent Doctor

Medical History

Child's Name_____

DENTAL HISTORY **yes** **no** office use

1. What is the reason for today's visit? _____
   _____
2. Is this your child's first visit to the dentist? …… ☐ ☐
3. If not, how long since the last visit to a dentist? _____
4. Previous dentist's name _____ in which city?_____
5. How do you think he/she will act toward the dentist? _____
   _____
6. My child has had x-rays taken prior to this visit. …… ☐ ☐
7. My child's teeth are brushed ____ times and flossed___ time per day.
8. Is your community water supply fluoridated? ☐ ☐
9. Do you drink tap water? ☐ ☐
10. Does your child receive fluoride supplements? ☐ ☐
    ☐Drops or tablets ☐Rinse or gel ☐Toothpaste
11. Have any cavities been noted in the past? …… ☐ ☐
12. Has your child ever had occlusal sealants? …….. ☐ ☐
13. Has your child received local anesthetic? …….. ☐ ☐
14. Have any teeth been removed by extraction? …… ☐ ☐
15. Has a space maintaining appliance been placed or recommended? ☐ ☐
16. My child has sustained a dental injury (falls, blows, chips, etc.) … ☐ ☐
17. Does your child have any oral habits (e.g. finger sucking, pacifier?) ☐ ☐
18. Has your child had an unfavorable experience at another office? ☐ ☐
    Please describe _____
    _____
19. Has anyone in the family, including parents, had Orthodontics? ☐ ☐
    Who? _____
20. Has your child been seen by an orthodontist? …… ☐ ☐
21. Has your child ever worn orthodontic appliances? …… ☐ ☐
22. Are you personally interested in a referral to an adult general dentist? ☐ ☐
23. Does your child believe there is anything wrong with his/her teeth? ☐ ☐

24. Specific information you would like covered during your child's visit today.
    _____
    _____
    _____
    _____
25. Dental questions you would like to discuss today
    _____
    _____
    _____
    _____

Dental History