dental care group kids

Date: _____

Patients Full Name: _____

Age: Birthdate: Sex: Nickname of Child: Sisters Name & Ages: _____

Responsible for Financial Charges: Mother Father Brothers Name & Ages: _____

Mother's Name:	Father's Name:
Address Street City Zip	Address Street City Zip
Home Phone: Cell:	Home Phone: Cell:
Occupation:	Occupation:
Bus. Address & Phone:	Bus. Address & Phone:
E-mail:	E-mail:

Dental Insurance? Yes ☐ No ☐ Insurance Company and Address: _____

Parents Social Security Number and Date of Birth: Mother: _____ __/__/__ Father: _____ __/__/__

Referred by: _____ School: _____

MEDICAL HEALTH

General Health (please check ✓ one): EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

Name and Address of Physician: _____

Has the Patient been told by a physician that he/ she needs to take antibiotics before Dental treatment: _____

Last complete physical date: _____ For what purpose: _____

Injuries to teeth, mouth, head or neck: _____ Specific Medical Condition: _____

Are you taking any medication now? YES ☐ NO ☐ Learning Disabilities: _____

If YES, please specify _____ Has the patient ever had an operation: _____

History of missing or extra teeth in family YES ☐ NO ☐ If YES, please specify _____

Has child ever been treated for:

Heart disease (Mitral Valve Prolapse)	YES ☐	NO ☐
Congenial heart lesions	YES ☐	NO ☐
Heart murmur	YES ☐	NO ☐
HIV (Immunopressive disorder)	YES ☐	NO ☐
Rheumatic fever	YES ☐	NO ☐
Anemic	YES ☐	NO ☐
Abnormal blood pressure	YES ☐	NO ☐
Jaundice	YES ☐	NO ☐
Ulcers	YES ☐	NO ☐
Diabetes	YES ☐	NO ☐
Tuberculosis or lung disease	YES ☐	NO ☐
Mental or nervous disorders	YES ☐	NO ☐
Allergic to Latex:	YES ☐	NO ☐

Hepatitis	YES ☐	NO ☐
Persistent Cough	YES ☐	NO ☐
Sinus trouble	YES ☐	NO ☐
Asthma or hay fever	YES ☐	NO ☐
High fever	YES ☐	NO ☐
Epilepsy	YES ☐	NO ☐
Psychiatric treatment	YES ☐	NO ☐
Are you allergic to penicillin	YES ☐	NO ☐
Are you allergic to codeine	YES ☐	NO ☐
Are you allergic to aspirin	YES ☐	NO ☐
Injected anesthetics	YES ☐	NO ☐
Are you subject to prolonged bleeding	YES ☐	NO ☐
Other	YES ☐	NO ☐
Communication assistance	YES ☐	NO ☐

I certify that I have read and understand the above questions. I will not hold my dentist or any other members of his/ her staff responsible for any errors or omissions I may have made in the completion of this form.
I have read and responded truthfully to the above questions and understand that I am responsible for payment for the Dental Work accomplished at this office. Should the account be referred to an attorney for collection, the undersigned shall pay reasonable attorney's fees and collections expense.

_____
Print Name of Responsible Party

_____
Signature of Responsible Party

_____
Relationship to Patient

_____
Primary language

_____
Print Patient's Name

_____
Patient's Signature

_____
Date

Doctors Initials: _____

dental care group kids

Fecha: _____

Nombre de paciente: _____

Edad: **Fecha de nacimiento:** **Sexo:** **Nombre y edad de hermanas:** _____

Responsibilidad de Cobros financiales: **Madre** **Padre** **Nombre y edad de hermanos:** _____

Nombre de madre:	**Nombre de padre:**
Direccion Calle Ciudad Codigo Postal	Direccion Calle Ciudad Codigo Postal
Telefono de la casa: Celular:	Telefono de la casa: Celular:
Ocupacion:	Ocupacion:
Direccion y telefono de trabajo:	Direccion y telefono de trabajo:
E-mail:	E-mail:

Seguro Dental ? Si ❑ No ❑ Nombre y direccion del seguro dental: _____

Numero de seguro social de los pedres: Madre: _____ ___/___/___ Padre: _____ ___/___/___

Referido por: _____ Nombre de escuela: _____

HISTORIA MEDICA

Salud general (por favor seleccione uno): EXCELENTE ❑ BIEN ❑ REGULAR ❑ POBRE ❑

Nombre y direccion de medico: _____

Alguna vez le ha dicho un médico que el paciente necesita tomar antibioticos antes del tratamiento dental: _____

Fecha del ultimo examen fisco: _____ Cual fue el proposito? _____

Sulfrido alguna lesion en los dientes la boca, la cabeza, o el cuelion: _____

Esta tomando alguna medicamento? SI ❑ NO ❑ Algun problema de aprendizaje: _____

En caso a firmutivo, especifique _____ Aliguna condicion fisica: _____

Historia de dientes faltantes o extra en la familia SI ❑ NO ❑ El paciente ha tenido alguna operacion: _____

Encaso afirmativo, especifique: _____

Ha sido su hijo(a) tratado para:

Enfermedad de corazon	SI ❑	NO ❑
(prolapse de la valv la mitral)	SI ❑	NO ❑
Lesiones congenito le corazon	SI ❑	NO ❑
Soplo de corazon	SI ❑	NO ❑
Sida	SI ❑	NO ❑
Fiebre Reumatica	SI ❑	NO ❑
Anemia	SI ❑	NO ❑
Presion abnormal de la sangre	SI ❑	NO ❑
Ictericia	SI ❑	NO ❑
Ulceras	SI ❑	NO ❑
Diabetis	SI ❑	NO ❑
Enfermedad del pulmon o	SI ❑	NO ❑
Tuberculosis:	SI ❑	NO ❑
Alguna alergia a latex	SI ❑	NO ❑
Hepatitis	SI ❑	NO ❑
tos persistente	SI ❑	NO ❑
Problema de sinusitis	SI ❑	NO ❑
Asma	SI ❑	NO ❑
Fiebre alta	SI ❑	NO ❑
Epilepsia	SI ❑	NO ❑
Tratamiento psiquiatrico	SI ❑	NO ❑
Alergico a la penicilina	SI ❑	NO ❑
Alergico a la codeina	SI ❑	NO ❑
Alergico a la aspirina	SI ❑	NO ❑
Inyectado con anestesias	SI ❑	NO ❑
Sangramiento prolongado	SI ❑	NO ❑
Otras cosas	SI ❑	NO ❑
Necesita asistencia para comunicarse	SI ❑	NO ❑

Yo certifico que he leido y entendido lo anterior. Reconozco que las preguntas han sido respondidas a mi satisfaccion. Yo no hare responsable a mi dentist o cualquier otro miembro de su personal, responsible de cualquier accion que tome o no tome debido a errors u omisiones que yo pueda haber cometido al llenar este formulario. He recibido informacion escrita sobre las directrices anticipadas. (Si procede)

_____
Escribe en letra moloe
Nombre del responsible legal

_____
Firma nombre responsible

_____
Relacion al paciente

_____
Lengua materna

_____
Escriba en letra molde
Nombre del paciente

_____
Firma del paciente

Iniciales
Del doctor: _____

_____
Facha

dental care group kids

Infants • Children • Teens • Hospital Dentistry

BROKEN APPOINTMENT POLICY

When you reserve a time with us please make every attempt to make your appointment. This reserved time is set aside specifically for your child. You will receive reminder notices months, weeks and days prior to your appointment. When you receive this message, please call, text or email us to confirm the time you already have reserved. If we have not heard back from you ***2 business days*** *prior to your reserved time, we will take your appointment off of our schedule.*

CANCELLATION POLICY

If you need to change or reschedule your reserved appointment with us, kindly give us a ***48 hour*** *notice so that we are able to reach out to another parent who's child is waiting for treatment. This may sound harsh, but please understand that if you have TWO broken appointments we reserve the right to dismiss you as a patient from our Dental Practice.*

Late Arrivals

If you are over 15 minutes late *for your appointment, we reserve the right to reschedule your appointment. Please understand that we strive to stay on time for your appointment as well as those patients that follow you.*

By signing below, you have read, and understand this agreement.

_____ _____ _____

Signature of Patient/Parent *Child's Name* *Date*

2797 NE 207 Street • Suite 201 • Aventura, FL 33180
Phone: 305.935.1613 • Fax: 305.935.4258