Safari Smiles Dental

800 Morning Star Drive, Sonora, CA 95370
Tel. 209-588-8400

CHILD'S INFORMATION

Child's Name: ____________________ M [ ] F [ ] Birthdate: ____________

MOTHER'S INFORMATION

Name: ____________________ Marital Status: __________ Birthdate: ____________

Social Security No. ____________________ Email Address: ____________________

Address: ____

Home No:. ______________ Work No.:______________ Cellular No: ______________

FATHER'S INFORMATION

Name: ____________________ Marital Status: __________ Birthdate: ____________

Social Security No. ____________________ Email Address: ____________________

Address: ____

Home No:. ______________ Work No:. ______________ Cellular No:. ______________

EMERGENCY CONTACT

Name: ____________________ Relationship: ______________

Address: ____

Home No. ______________ Work No. ______________ Cellular No. ______________

PRIMARY DENTAL INSURANCE

Policy Holder's Name: ____________________ Relationship to Patient: ______________

Policy Holder's Birthdate: ______________ Social Security No.: ____________________

Policy Holder's Employer: ____

Insurance Co. Name: ____________________ Insurance Co. Phone No.: ______________

Insurance Policy Group no.: ____________________ Policy Holder's ID No.: ______________

SECONDARY DENTAL INSURANCE

Policy Holder's Name: ____________________ Relationship to Patient: ______________

Policy Holder's Birthdate: ______________ Social Security No.: ____________________

Policy Holder's Employer: ____

Insurance Co. Name: ____________________ Insurance Co. Phone No.: ______________

Insurance Policy Group no.: ____________________ Policy Holder's ID No.: ______________

DENTAL AND MEDICAL HISTORY

Is this your child's first visit to the dentist? Yes [ ] No [ ] If not, when was his last visit? ___________________

Were x-rays taken at previous dental visits? Yes [ ] No [ ] Name of previous dentist: _____________________

Does your child need to pre-medicate prior to dental appointments? Yes [ ] No [ ] If yes, please explain: ____

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Has your child ever had any unfavorable reaction from previous dental or medical treatment? Yes [ ] No [ ]

If yes, please explain: ____

Does your child brush his/her teeth daily? Yes [ ] No [ ] Reason for this visit: ___________________________

Has there been a change in your child's general health in the past year? Yes [ ] No [ ] If yes, please explain __

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Is your child under the care of a physician for a medical disorder and is he/she taking medication regularly?

Yes [ ] No [ ] If yes, please explain ____

Please check any of the following to which your child is allergic: Latex [ ] Penicillin [ ] Dental Anesthetics [ ]

Is your child subject to the following (please circle answer):

Nervous disorders/fainting/Dizziness? Yes / No
Bruise Easily? Yes / No
Injuries to teeth, face or mouth? Yes / No
Blood or bleeding Disorder? Yes / No
History of heart trouble, diabetes, asthma, Epilepsy, rheumatic fever, tuberculosis? Yes / No
Please explain "yes" answers: ____

Please list all other diseases or medical issues your child currently has or has had in the past: ________

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AUTHORIZATION (Please initial each paragraph)

______ I request and authorize dental treatment and procedures for my minor child during the taking of dental x-rays and use of local anesthetics and/or nitrous oxide as may be necessary.

______ I understand that Safari Smiles Dental will bill my dental insurance as a courtesy but that I am ultimately responsible for all charges should my insurance company not pay for any reason. I also understand that my portion is due at the time treatment is rendered.

______ I will read the Notice of Privacy Practices which is available at the dental office.

We, at Safari Smiles Dental, understand that your time is valuable and ask that you kindly provide us with at least a 48 hours notice if you need to change or cancel your child's appointment.

Who may we thank for referring you to our office?____

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Signature of Patient's Parent or Guardian