



TONG
DENTAL
CARE

WELCOME TO OUR PRACTICE!

Thank you for trusting us with your children's dental care. Our goal is to make every child's visit pleasant and educational. We strive to teach your child good oral care which will help keep their smiles beautiful for their lifetime.

CHILDREN'S INFORMATION

Patient's Name: _____
Last First Middle

Date of Birth: _____

School: _____

Child's Home Phone Number: _____

Child's Home Address: _____ City: _____ State: _____ Zip: _____

Name and Age of Brothers/Sisters: _____

Interests or hobbies: _____

Whom may we thank for referring you? _____

Person Responsible for the Account: _____ Relationship: _____

Home Number: _____ Work Number: _____ ext: _____ SSN: _____

Parent's Marital Status: Single Married Divorced Separated Widowed

PARENTS INFORMATION

Mother Stepmother Guardian

Name: _____ DOB: _____

Wk #: _____ Cell #: _____ Hm #: _____

Employer: _____

Occupation: _____

SS#: _____ Email: _____

Father Stepfather Guardian

Name: _____ DOB: _____

Wk #: _____ Cell #: _____ Hm #: _____

Employer: _____

Occupation: _____

SS#: _____ Email: _____

INSURANCE INFORMATION

Primary Dental Insurance

Insurance Co. Name: _____

Ins. Co. Address: _____

Ins. Co. Phone #: _____

Group (Account or Policy) #: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's DOB: _____ SSN: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Ins. Co. Address: _____

Ins. Co. Phone #: _____

Group (Account or Policy) #: _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's DOB: _____ SSN: _____

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Name: _____ DOB: _____

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Policy Owner's Employer: _____

Policy Owner's Employer: _____

Employer's Address: _____

Employer's Address: _____

DENTAL HISTORY

Why did you make this appointment? _____

Has your child ever had an unpleasant dental experience? No Yes _____

Have your child's teeth ever been injured? No Yes _____

Were there any problems with the birth or pregnancy? No Yes _____

Have the child ever had any pain/tenderness or popping noise in his/her jaw joint? No Yes _____

Is the child nervous about this appt? No Yes Does/Did the child have any of the following habits:

Is the child's drinking water fluoridated? No Yes Bottle to bed at night Use a pacifier

Is the child taking fluoridated supplements? No Yes Thumb/finger sucking Lip sucking/biting

Does the child brush his/her teeth daily? No Yes Mouth breathing

Do you help your child brush? No Yes Other: _____

Does the child floss his/her teeth daily? No Yes Date of last dental exam: _____

Was the child breast fed? No Yes Name of previous dentist: _____

MEDICAL HISTORY

Are you currently under the care of a physician? No Yes Date of last dental exam: _____

Physician: _____ Phone #: _____ Address: _____

Do your child have any history of the following diseases or conditions?

	No	Yes		No	Yes		No	Yes
Abnormal Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Liver Problems	<input type="checkbox"/>	<input type="checkbox"/>
Accidents/Severe Infections	<input type="checkbox"/>	<input type="checkbox"/>	Convulsion/Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>
Any hospital stay/operations	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Mental Retardation	<input type="checkbox"/>	<input type="checkbox"/>
Anemia/Blood Disorders	<input type="checkbox"/>	<input type="checkbox"/>	Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	Measles/Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>
HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Emotional/Behavioral Prob.	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic/Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Asthma/Lung Problems	<input type="checkbox"/>	<input type="checkbox"/>	Handicaps/Disabilities	<input type="checkbox"/>	<input type="checkbox"/>	Speech/Learning Disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cancer/Tumors	<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur/Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>

Please describe any serious medical problems that your child may have: _____

Please describe your child's current physical health: Good Fair Poor

Please list all drugs that your child is currently taking: _____

Please list all drugs that your child is allergic to: _____

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

Assignment and Release

I, the undersigned, certify that I (or my dependant) have insurance coverage and sign directly to Dr. Tong all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature Relationship: _____ Date: _____

OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the patient named herein: _____

Reviewer: _____ Date: _____

Doctor's Comments: _____
