



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: \_\_\_\_\_

[Continued from front]

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: \_\_\_\_\_