Discovery Pediatric Dentistry
1700 California Street, Suite 200
San Francisco, CA 94109-4582

Get Acquainted Questionnaire
www.PediatricDentistSF.com

We would like to welcome you and your child to our office

Please tell us about your child

Patient Name. . . . . Age. . . . . Birthdate. . . . . .
Patient Social Security Number. . . . . Sex M or F Weight. . . . . .
Is your child here for a specific reason or in pain? If so, for what? . . . . . .

. . . . . .

Medical Doctor . . . . . Telephone # ( ) . . . . . .

Address. . . . . FAX # ( ) . . . . . .

Names of other children in your family. . . . . .

(First Name, Last Name, Age) . . . . . .

Review of Health History

Yes	No	
❑	❑	Has your child been to the hospital or had a serious injury in the last six months?
❑	❑	Is your child presently under the care of a physician for any medical problem?
❑	❑	Is your child currently taking any medication or herbal supplements?
❑	❑	Is your child allergic to any food, medicines (ie. **peniciillin**), or **LATEX**?
❑	❑	Any immunocompromised conditions, organ transplant, ARC, or HIV?
❑	❑	For women only, pregnant? If so, how many months? .....

Office Use
_____
_____
_____
Doctor's Initials Date

Does your child now have or has your child ever had a history of any of the following?

Yes	No		Yes	No	
❑	❑	Allergies to Medications, Peanuts, Latex, etc	❑	❑	Eye Problems / Glaucoma
❑	❑	Anemia	❑	❑	Genetic Syndrome
❑	❑	Asthma / Other Lung Disease	❑	❑	Hearing / Speech Problems
❑	❑	Autism/Mental / Emotional Problems	❑	❑	Heart Disease / Murmur / Defect / Surgery
❑	❑	Autoimmune Disease (AIDS)	❑	❑	Heomphilia or Bleeding Problems / Bruises Easily
❑	❑	Birth Defects / Congenital Disease	❑	❑	Hepatitis or Live Disease
❑	❑	Bone or Joint Problems or Surgery	❑	❑	Herpes / Venereal Disease
❑	❑	Cancer / Malignancies / Leukemia	❑	❑	Kidney Disease or Bladder Condition
❑	❑	Cerebral Palsy	❑	❑	Premature Birth
❑	❑	Chronic Tonsil / Adenoid / Ear Infections	❑	❑	Rheumatic Fever
❑	❑	Convulsions / Seiures / Epilepsy / Fainting	❑	❑	Sickle Cell Anemia
❑	❑	Developmental Delay	❑	❑	Tuberculosis (TB)
❑	❑	Diabetes	❑	❑	Other . . . . .

If you answered yes for any question above, please explain . . . . . .

. . . . . .

Is there anything of importance in your child's health history that has not been asked about or anything else that you think we should know about your child?

If so, what? . . . . . .

Review of Dental History

Would you describe your child as: ❑ shy / timid ❑ frightened ❑ apprehensive ❑ outgoing ❑ other . . . . . .

Has your child been to another dental office? If yes, which office? ..... When? . . . . . .

Has your child had problems with prior dental treatment? If yes, please describe. . . . . .

Has your child ever been sedated for dental treatment? If yes, please describe. . . . . .

How did you find out about our office? (Please check ALL that apply)

❑ Discovery Pediatric Dentistry Website: **www.PediatricDentistSF.com**

❑ Google.com	❑ Doctor Oogle.com	❑ YP.com (Yellow Pages.com)	❑ Yahoo.com
❑ Demandforce.com	❑ Dentists4Kids.com	❑ AT&T Yellow Pages Directory	❑ Yelp.com

❑ Parent's / Mother's Group, which one? . . . . . ❑ Insurance Website, which one? . . . . . .

If a friend, relative, or Doctor referred you to our office, whom may we thank for the referral?

Please indicate their name and address below: ❑ Friend or Relative ❑ Medical Office ❑ Dental Office

Name. . . . . Is this the Parent or Patient's Name (Please Circle Which One)

Address…….. Telephone # ( ) . . . . . .

FAMILY INFORMATION AND FINANCIAL RESPONSIBILITY

Father / Stepfather / Partner / Legal Guardian Information

Name. . . . . DOB. . . . . .

SSN #. . . . . or Tax ID # . . . . . .

Driver's License # . . . . . State . . . . . Exp . . . . . .

Home Address . . . . . Apt. # . . . . . .

City . . . . . State . . . . . ZIP . . . . . .

Home # . . . . Celular # . . . . . .

Is it okay to contact this Paren ton your Cellular Number? Yes No

E-mail address. . . . . . .

Is it okay to contact this Parent via e-mail? Yes No

Employer. . . . . . .

Address. . . . . .

City. . . . . . State. . . . . ZIP. . . . . .

Business # ( ). . . . . Ext. . . . . .

Occupation. . . . . .

❑ **Patient lives with this Parent**

Mother / Stepmother / Partner / Legal Guardian Information

Name. . . . . DOB. . . . . .

SSN # . . . . . or Tax ID # . . . . . .

Driver's License # . . . . . State. . . . . Exp . . . . . .

Home Address . . . . . Apt. # . . . . . .

City . . . . . State . . . . . ZIP .. . .

Home # . . . . Cellular # . . . . . .

Is it okay to contact this Parent on your Cellular Number? Yes No

E-mail address. . . . . .

Is it okay to contact this Parent via e-mail? Yes No

Employer. . . . . . .

Address. . . . . .

City. . . . . State . . . . . ZIP . . . . . .

Business # ( ). . . . . Ext. . . . . .

Occupation. . . . . .

❑ **Patient lives with this Parent**

Person responsible for this account ❑ Father ❑ Mother ❑ Other. . . . . .

Person responsible for scheduling appointments ❑ Father ❑ Mother ❑ Other. . . . . .

Does your child have other dental insurance coverage? ❑ Yes ❑ No

A secondary Insurance coverage will probably help minimize or may even eliminate your out of pocket expense. The additional coverage may also help with procederes not covered by your primary insurance (e.g. White fillings and preventive sealants). If you have questions about how secondary coverage works, our staff will be happy to help you by giving you advice about both insurance coverages. We can verify your secondary Insurance and obtain more benefits for you.

Primary Insurance Carrier ……
Second Insurance Carrier ……
Third Insurance Carrier ……

Contact Person (Friend or Relative WITH DIFFERENT PHONE NUMBERS THAN ABOVE)

Name …… Home # ( )…….. Cellular # ( )……..

Relationship…… E-mail Address. . . . . Work # ( )…….

I certify that I have read and understand this form. To the best of my knowledge, I have answered every question completely and accurately. I will inform the office of any change in my child's health and/or medications, family information, financial responsibility, or insurance coverage. Further, I will not hold Discovery Pediatric Dentistry or any memeber of our staff responsible for any errors or omissions that I may have made in completion of this form. The practice of dentistry involves treating the whole person. If our Doctors determine that there may be a potentially medically compromised situation, medical consultation may be needed prior to starting dental treatment. I authorize Discovery Pediatric Dentistry to contact my physician.

Signature of Parent or Legal Guardian _____ **Date** _____

RECALL OR EMERGENCY UPDATE: Have there been any changes in your child's health history since you originally filled out this form?
If so, please indicate changes in boxes below? ↓

Office Use Only

Date	***Parent Signature***	**Changes**	***DDS***
Date	***Parents Signature***	**Changes**	***DDS***
Date	***Parent Signature***	**Changes**	***DDS***

Questionnaire Update:

An update and completely new Get Acquainted Questionnaire is <u>required every 12 months</u> as per the American Academy of Pediatric Dentistry Standard of Care. This is required for the benefit and safe treatment of your child and for the compléteness of his/her records.

Keeping Your Appointments If you are unable to keep your appointment, **you need to contact our office during regular office hours**. Failure to give adequate notice may result in a Missed Appointment Fee. No charge will be made for rescheduling your appointment if a 48 hour notice is given to on of our reception staff, so that your child's reserved time can be given to another patient. **We do not consider a message left on or with the answering service as 48 hour notice. You need to call and speak with one of our reception staff during normal business hours.**

Revised: 10/17/13