Captain Floss Children's Dentistry & Orthodontics

6221 Metropolitan St # 202 • Carlsbad, CA 92009 (760)438-1279

New Patient Information

Please let us know about you or your child's medical and dental history so we may serve you more effectively and in a manner that helps with the overall health and well-being of you/your child. We realize that not all questions will pertain to you/your child. If you have questions, please let us know.

Chart#: ____________
FOR OFFICE USE ONLY

Patient Name: ____________ * ____________ * ____ ____________
Last First MI Preferred Name

Title: ____________
Mr/Ms/Mrs/etc

Gender:* ○ Male ○ Female

Family Status:* ○ Married ○ Single ○ Child ○ Other

Birth Date:* ____________ **Prev. Visit:** ____________ **Email Address:** ____________

Phone: ____________ * ____________ ____________ ____________ **Best time to call:** ____________
Home Mobile Work Ext

Address: ____________ * ____________
Address 1 Address 2

____________ * ____________ * ____________
City State Zip Code

Who does the child live with? *

☐ Mother ☐ Father ☐ Guardian ☐ Grandparents

Is there anything that you would like to discuss with the Dentist in private, alone, or away from your child? * ○ Yes ○ No

Child's Hobbies/Sports:

Responsible Guardian Information (Guardian Accompanying)

The following is for:* ◯ the patient's spouse ◯ the person responsible for payment ◯ both ◯ neither-not applicable

Name: ______________________* ______________________* ____ ______________________
Last First MI Preferred Name

Title: __________ **Gender:*** ◯ Male ◯ Female **Family Status:*** ◯ Married ◯ Single ◯ Child ◯ Other
Mr/Ms/Mrs/etc

Birth Date:* __________ **Email Address:** ______________________________

Phone: ______________* ______________ ______________ ______ **Best time to call:** ______________
Home Mobile Work Ext

Address: ______________________________* ______________________________
Address 1 Address 2

______________________________* ________* _____-____*
City State Zip Code

SSN: * ______________________

Whom may we thank for referring you to our practice? (I.E. Dentist, Yelp, Google)

____

Additional Parental or Guardian Information:

Name: Last, First

____

____

Address, City, State, and Zip (only if different from responsible party)

____

____

Phone Number: (Home and Cell Please) ______________

Social Security Number: ______________

Date of Birth: ____________

Employer Name and Occupation:

____

____

Dental Benefits Plan

Primary

Name of Insured: ______________________ * ______________________ * ____
Last First MI

Patient's relationship to insured:* ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name:* ______________________

Insurance Company Address and Phone Number: *

Subscriber's Employer: *

Subscriber's Date of Birth: *

Subscriber/Member ID *

Group Number:

Subscriber's Social Security #:

Secondary

Name of Insured: ______________________ ______________________ ____

Last First MI

Patient's relationship to insured: ◯ Self ◯ Spouse ◯ Child ◯ Other

Insurance Plan Name: ______________________

Insurance Company Address and Phone Number:

Subscriber's Employer:

Subscriber's Date of Birth:

Subscriber/Member ID:

Group Number:

Subscriber's Social Security #:

☐ * **By checking this box,**
I authorize my insurance company to pay the dentist all insurance benefits rendered.
I authorize the use of this electronic signature on all insurance submissions.
I authorize the dentist to release all information necessary to secure the payment of benefits.
I understand that I am financially responsible for all charges whether or not paid by insurance.

Medical History

What is the approximate date of your child's last medical exam? * ______________________

Please check any of the following which apply to your child, and add any relevent comments:

Currently taking any medications? * ◯ Yes ◯ No

If yes, list:

____

____

Allergic to any medications? * ◯ Yes ◯ No

If yes, list:

____

____

Allergies to Latex or Food? * ◯ Yes ◯ No

If yes, list:

____

____

History of major illness? * ◯ Yes ◯ No

If yes, list:

____

____

- ☐ Had complications with or after dental treatment.
- ☐ Has been seen by a cardiologist.
- ☐ Taking any perscription or non-perscription medications.
- ☐ Any other conditions, diseases, etc. not listed above.
- ☐ Currently under the care of a physician due to a specific condition.
- ☐ Been admitted to a hospital in the last 5 years due to a surgery or illness.
- ☐ Tobacco use (chewing or smoking.)

Please mark YES if your child has any history of the following conditions, For each "YES" provide details at the bottom of the list. Mark NO after each line if none of those conditions applies to your child.

Complications before or during birth, prematurity, birth defects, syndromes or inherited conditions? * ◯ Yes ◯ No

Sleep apnea/snoring, mouth breathing, or excessive gagging? * ◯ Yes ◯ No

Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease? * ◯ Yes ◯ No

Asthma, reactive airway disease, wheezing, or breathing problems? * ◯ Yes ◯ No

Developmental disorders, learning problems/delays, or intellectual disability? * ◯ Yes ◯ No

Cerebral palsy, brain injury, epilepsy, or convulsions/seizures? * ◯ Yes ◯ No

Autism/autism spectrum disorder ASD? * ◯ Yes ◯ No

Attention deficit/hyperactive disorder (ADD/ADHD)? * ◯ Yes ◯ No

Behavioral, emotional, communication, or psychiatric problems/treatment? * ◯ Yes ◯ No

Abuse (physical, psychological, emotional, or sexual) or neglect? * ◯ Yes ◯ No

Diabetes, hyperglycemia, or hypoglycemia? * ◯ Yes ◯ No

Hemophilia, bruising easily, or excessive bleeding? * ◯ Yes ◯ No

Transfusions or receiving blood products? * ◯ Yes ◯ No

Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow organ transplant? * ◯ Yes ◯ No

Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staph aureus (MRSA), sexually transmitted infections (STI), human immunodeficiency virus (HIV), AIDS? *

◯ Yes ◯ No

Please provide details to any above "YES" answers here:

____

____

____

DENTAL HISTORY

Is this your child's first visit to the dentist? * ◯ Yes ◯ No

have there been any injuries to the face, mouth, or teeth? * ◯ Yes ◯ No

If yes please explain:

____

____

Has the child ever had serious or difficult problem associated with previous dental work? * ◯ Yes ◯ No

If yes please explain:

____

____

Nursing or bottle habits beyond age one? ◯ Yes ◯ No

Clenching/grinding his/her teeth? ◯ Yes ◯ No

Jaw joint problems (popping, locking, etc.)? ◯ Yes ◯ No

Acknowledgments

☐ * **By checking this box, I acknowledge that I have reviewed ALL questions/alerts on this questionnaire and responded accordingly. There are no other medical conditions or medications/allergies that have not been listed. I am aware that I must notify the practice of any future changes in my child's health.**

Consent for Services

I, THE RESPONSIBLE GUARDIAN, hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my child's health.

I authorize the diagnosis of my child's dental health by means of radiographs, study models, photographs, or other diagnostic aids deemed appropriate.

I authorize the dentist to release any information including the diagnosis and records of treatment or examination for myself and my dependent to third-party insurance carriers, payers, and/or healthcare practitioners. I authorize the payment of my insurance carrier to submit payment directly to the dentist or dental practice to be applied to my account.

I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance and I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on behalf of my children/dependents.

I also ackowledge a $25 missed appointment fee that will apply to all cancellations made within 2 business days of the scheduled appointment. Emergencies will not apply.

☐ * **By checking this box, I acknowledge that I have read the above conditions of treatment and payment and agree to their content. This will serve as my electronic signature.**

HIPAA Acknowledgement

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form.

I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

☐ * **By checking this box, I understand the above information and agree with its contents, and this will serve as my electronic signature for the HIPAA Disclosure Form. This will serve as my electronic signature.**

Response Date: ____/____/________