Welcome to our office

Westside Dental Associates

Les Latner, DDS (310) 477-1081

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as possible. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

DATE: _____

NAME OF MINOR / CHILD _____
LAST NAME FIRST NAME MIDDLE

SEX: ☐ M ☐ F AGE:_____ BIRTHDATE: _____ NICKNAME: _____

HOME ADDRESS: _____
CITY STATE ZIP

HOME PHONE: ( ) _____ STUDENT? ☐F/T ☐P/T SCHOOL _____

BIRTH DATE: _____

Who may we thank for referring you to us? _____

RESPONSIBLE PARTY _____
FIRST LAST

PARENT'S STATUS:

☐ SINGLE ☐ WIDOWED ☐ REMARRIED ☐ PARTNER

☐ MARRIED ☐ DIVORCED ☐ SEPARATED ☐ OTHER

DO YOU HAVE LEGAL CUSTODY OF THIS CHILD ? ☐ Y ☐ N

PARENT INFORMATION

☐ MOTHER ☐ STEPMOTHER ☐ GUARDIAN

NAME:_____ BIRTH DATE:_____

WORK PHONE: _____ HOME PHONE: _____

CELL PHONE: _____ FAX: _____

EMAIL: _____

SS# _____ DR. LIC# _____

☐ FATHER ☐ STEPFATHER ☐ GUARDIAN

NAME:_____ BIRTH DATE:_____

WORK PHONE: _____ HOME PHONE: _____

CELL PHONE: _____ FAX: _____

EMAIL: _____

SS# _____ DR. LIC# _____

INSURANCE INFORMATION

NAME_____
FIRST LAST

ADDRESS _____

CITY, STATE ZIP _____

PHONE #: HOME _____ WORK _____

BIRTH DATE _____ SS# _____

EMPLOYER _____

DENTAL INSURANCE CO _____

GROUP / POLICY # _____

PHONE # ( ) _____

NAME_____

ADDRESS _____

CITY, STATE ZIP _____

PHONE #: HOME _____ WORK _____

BIRTH DATE _____ SS# _____

EMPLOYER _____

DENTAL INSURANCE CO _____

GROUP / POLICY # _____

PHONE # ( ) _____

MY PREFERRED METHOD OF PAYMENT IS

☐ CASH OR CHECK ☐ CREDIT CARD ☐ MONTHLY FINANCING

I understand and accept responsibility for all dental services provided.

_____
SIGNATURE DATE

CHILD'S HEALTH HISTORY

Is the child currently under a physician's care? ☐ Y ☐ N

Physician's name: _____ Physician's phone number: _____ Date of last visit _____

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

List all drugs that the child is currently taking: _____

List all drugs, foods and materials to which the child is allergic: _____

_____

Any hospital stays?	☐ Y	☐ N	AIDS or ARC (Aids related complex)?	☐ Y	☐ N
Any operations?	☐ Y	☐ N	HIV + (HIV positive)?	☐ Y	☐ N
Fainting spells/loss of consciousness ?	☐ Y	☐ N	Skin Blotches or rashes?	☐ Y	☐ N
Seizures?	☐ Y	☐ N	Measles?	☐ Y	☐ N
Numbness, tingling or paralysis?	☐ Y	☐ N	Rheumatoid arthritis?	☐ Y	☐ N
Breathing problems?	☐ Y	☐ N	Unexplained vomiting/frequent nausea?	☐ Y	☐ N
Asthma or emphysema?	☐ Y	☐ N	Hepatitis?	☐ Y	☐ N
Tuberculosis or persistent cough?	☐ Y	☐ N	Jaundice?	☐ Y	☐ N
Coughed up blood?	☐ Y	☐ N	Kidney/liver problems?	☐ Y	☐ N
Pneumonia?	☐ Y	☐ N	Sexually transmitted disease?	☐ Y	☐ N
Rheumatic fever?	☐ Y	☐ N	Unexplained gain or loss of weight (past 6 months)?	☐ Y	☐ N
Scarlett fever?	☐ Y	☐ N	Smoking or chewing tobacco use?	☐ Y	☐ N
Congenital heart disease/defect?	☐ Y	☐ N	Drink alcohol?	☐ Y	☐ N
Heart murmur	☐ Y	☐ N	Poor appetite?	☐ Y	☐ N
Other heart problems?	☐ Y	☐ N	Ever used intravenous drugs?	☐ Y	☐ N
Abnormal bleeding?	☐ Y	☐ N	Substance abuse?	☐ Y	☐ N
Bruise easily/bleed excessively after a cut?	☐ Y	☐ N	Used cocaine or crack (past 6 months)?	☐ Y	☐ N
Hemophlia?	☐ Y	☐ N	ADD/ADHD (hyperactivity)?	☐ Y	☐ N
Blood transfusion?	☐ Y	☐ N	Autism?	☐ Y	☐ N
Denied permission to give blood?	☐ Y	☐ N	Physical handicap/disabilities	☐ Y	☐ N
Genetic disease/illness?	☐ Y	☐ N	Learning disabilities	☐ Y	☐ N
Anemia?	☐ Y	☐ N	Please discuss any serious medical problems the child		
Sickle cell disease or trait?	☐ Y	☐ N	experiences/experienced. _____		
Craniofacial anomalies?	☐ Y	☐ N	_____		
Cancer?	☐ Y	☐ N	_____		
Radiation or chemotherapy?	☐ Y	☐ N	Are the child's immunizations current?	☐ Y	☐ N
Diabetes?	☐ Y	☐ N	Is there anything that you would like to discuss with the doctor in private?	☐ Y	☐ N
Thyroid or adrenal gland disease?					

DENTAL HISTORY

What is the primary reason for today's visit to the dentist?

_____

Has your child experienced a difficult/serious problem associated with any previous dental or medical treatment?

If yes please explain: _____

Is your child often anxious or nervous?	☐ Y	☐ N	Is the child taking / taken fluoride supplements?	☐ Y	☐ N
Has your child every had psychological or psychiatric counseling?			Does your child use toothpaste with fluoride?	☐ Y	☐ N
Is the child's water fluoridated?	☐ Y	☐ N	Does your child eat toothpaste?	☐ Y	☐ N
Name of bottled water used _____			Has child had professional fluoride treatment?	☐ Y	☐ N
			Does the child brush his/her teeth daily?	☐ Y	☐ N
			Does your child floss daily?	☐ Y	☐ N
			Has your child ever experienced injury to his/her mouth, teeth or jaw?	☐ Y	☐ N
			If yes, explain: _____		
			Does child need antibiotics for dental treatment?	☐ Y	☐ N

ORAL HABITS & CONDITIONS

Does your child have any of the following habits/conditions?			Chewing on objects?	☐ Y	☐ N
Lip sucking/biting?	☐ Y	☐ N	Speech problems?	☐ Y	☐ N
Use/used pacifier	☐ Y	☐ N	Tongue thrust?	☐ Y	☐ N
Nail biting?	☐ Y	☐ N	Mouth breather?	☐ Y	☐ N
Thumb/finger sucking?	☐ Y	☐ N	Snoring?	☐ Y	☐ N

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent or guardian _____ Date _____

Dentist's Signature _____ Date _____