RETURNING PATIENT FORM

Patient Name (First and Last Name): _____ Date: _____

Phone: _____ 2nd Phone: _____Email: _____

Any changes to home address? If yes, please list new address below:

_____

Do you have a new dental insurance? If yes, please list Name and ID # below:

_____

Are you having dental pain today? ◯ YES ◯ NO

Please check any dental concerns:

◯ Cavities ◯ Color of Teeth ◯ Grinding of Teeth ◯ Gum Infections
◯ Jaw Sounds ◯ Mouth Breathing ◯ Orthodontics ◯ Sensitive Teeth
◯ Toothache ◯ Trauma ◯ None
◯ Other: _____

Have there any been changes in your child's medical history? ◯ Yes ◯ No
If yes: _____

Is your child currently taking any medications? ◯ Yes ◯ No
If yes, please list: _____

Any hospitalization or surgery since your child's last visit? ◯ Yes ◯ No

Is your child allergic to any food or medication? ◯ Yes ◯ No
If yes, please list: _____

Does your child begin to smoke cigarettes or use any tobacco products? ◯ Yes ◯ No
If yes, when and what products? _____

APPOINTMENT CANCELLATION AND NO-SHOW POLICY

When we make your appointment, we are reserving a room for your particular needs. We ask that if you must change an appointment, we require at least a 24-hour advanced notice. This courtesy makes it possible to give your reserved room to another patient who would like it. **Repeated cancellations with a maximum of three missed appointments without notice will result in loss of future appointment privileges.** We feel that our patient's time is valuable. When your appointment is made, a room is reserved, your records are prepared, and special instruments are readied for your visit. We, of course, would appreciate the same courtesy from you. If you have any questions or issues that are preventing you from keeping your appointments, please call us ahead of time at (209) 400-2018 and we will gladly reschedule your appointment to a more convenient time. I understand and agree to Bethel Kids Dental's policy about treatment appointment and cancellation.

I certify that I have read and understand the contents of this form. I will not hold Bethel Kids Dental, doctors, and staff, responsible for any action they take or do not take because of errors or omissions that I have made in completing this form. I will notify Bethel Kids Dental any changes on my child's information, and health.

Print: _____ **Signature:**_____ **Date:** _____

Bethel Kids DENTAL
531 W. Kettleman Lane, Lodi, CA 95240
1660 W. Yosemite Ave. #1, Manteca, CA 95337
3633 Bradshaw Rd. #A-D, Sacramento, CA 95827

HEALTH HISTORY FORM

Dental History

◯Yes ◯No Has your child ever been to the dentist? Date of last cleaning & x-rays (if taken) _____
◯Yes ◯No Has your child experienced any unfavorable reaction from previous dental care? If yes, please explain: _____
◯Yes ◯No Does your child suck a finger, thumb, or pacifier (please circle)? If yes, when? _____
◯Yes ◯No Does your child go to bed with a bottle or sippy cup? If yes, what is in it? _____
◯Yes ◯No Does your child snack frequently? What are their favorite snack foods? _____
◯Yes ◯No Has your child had local anesthetic? If yes, were there any problems? _____
◯Yes ◯No Has your child ever been sedated for dental treatment? If yes were there any problems?_____
◯Yes ◯No Have your child's teeth ever been injured? Which teeth: _____
◯Yes ◯No Has your child or anyone in your immediate family ever had a cold sore or other mouth ulcer? Please describe: _____
◯Yes ◯No Does your child use a fluoride toothpaste?
◯Yes ◯No Does your child begin to smoke cigarettes or use any tobacco products?

Please check if your child is having problems with any of the following:

◯Cavities ◯Color of Teeth ◯Grinding of Teeth ◯Gum Infections ◯Jaw Sounds
◯Mouth Breathing ◯Orthodontics ◯Sensitive Teeth ◯Trauma ◯Toothache
Other: _____

Medical History

Child's Physician/Pediatrician: _____ Phone: _____
◯Yes ◯No Is your child in good health? Date of last physical exam: _____
◯Yes ◯No Has your child ever had a health problem? _____
◯Yes ◯No Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Please explain: _____
◯Yes ◯No Is your child currently taking any medications? Please give medication, dose, and reason: _____
◯Yes ◯No Is your child allergic to any medications? Any food? If yes, please list what medication and/or food: _____
◯Yes ◯No Are your child's immunizations current?
◯Yes ◯No Have you ever been told that your child needs to take antibiotics before dental treatment?

Please check if your child has been treated for any of the following:

◯Abuse ◯Cancers/Tumors ◯Heart Murmurs ◯Sickle Cell Disease
◯ADHD ◯Cerebral Palsy ◯Hepatitis ◯Significant Injuries
◯Adverse Drug Reaction ◯Congenital Birth Defect ◯HIV/AIDS ◯Snoring
◯Anemia ◯Diabetes ◯Liver/GI Disease ◯Speech/Hearing Issues
◯Asthma/Breathing Problems ◯Endocrine/Growth Problems ◯Mental Delays ◯Spina Bifida
◯Autism ◯Eyesight Problems ◯Personality Problems ◯Tonsil Problems
◯Blood Transfusion ◯Frequent Infections ◯Recurrent Headaches ◯Tuberculosis
◯Blood Disorders ◯Heart Disease ◯Seizures
Other: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

Patient Name: _____

Parent/Guardian Signature: _____ **Date:** _____