Dr. Allan Pang, DMD
18805 Cox Avenue Suite #110
Saratoga, CA 95070
Phone: (408) 866-8883
Fax: (408) 516-8985
www.southbaykidsdentistry.com

REGISTRATION & HEALTH HISTORY FORM

Today's Date: _______________

WELCOME to our children's dental office with individualized care for infants, toddlers, children and teens! Our focus is on prevention & early management of disease. We are honored that you have entrusted your child's care to us. We take great pride in our expertise in managing children. Should you have any special requests, please inform us & we will do our best to accommodate them.

******* NOTE: The parent or guardian who accompanies the child is responsible for payment at the time of service

TELL US ABOUT YOUR CHILD:

Name____
Last First MI
Goes by ________________________ ☐ Male ☐ Female
Siblings that we treat _______________________________
Child's Birthdate_____ / _____ /_______ Age ___________
School ___________________________ Grade __________
Child's Home Address: ____
Child's Home Phone # (______)_________________________

WHO IS ACCOMPANYING THE CHILD TODAY?

Name ____
Relationship _______________________________________
Marital Status ☐ single ☐ married ☐ divorced
☐ adoptive parent ☐ foster parent

PARENT ONE - INFORMATION:

Name: ____
Parent Step-Parent Guardian DOB: ____ /____ /________
Employer ____
Home # (_____)____________________________________
Work # (_____)_____________________________________
Cell Phone # (_____)_________________________________
Email:____

PARENT TWO - INFORMATION:

Name: ____
Parent Step-Parent Guardian DOB: ____ /____ /_______
Employer ____
Home # (_____)____________________________________
Work # (_____)_____________________________________
Cell Phone # (_____)_________________________________
Email:____

PRIMARY DENTAL INSURANCE:

Insurance Name__________________________________
Insurance Co. Address_____________________________
____
Insurance Co. Phone # (_______)_______________________
Group # ____
Policy Owners Name_______________________________
Relationship to Patient____________________________
Policy Owners Birthdate_______ /_______ / _____________
Social Security / ID #______________________________
Policy Owner's Employer___________________________

SECONDARY DENTAL INSURANCE:

Insurance Name__________________________________
Insurance Co. Address_____________________________
____
Insurance Co. Phone # (_____)_______________________
Group # ____
Policy Owners Name_______________________________
Relationship to Patient____________________________
Policy Owners Birthdate_______ /_______ / _____________
Social Security / ID #______________________________
Policy Owner's Employer___________________________

WHO MAY WE THANK FOR REFERRING YOU TO OUR OFFICE?

____

DENTAL HISTORY:

Is this your child's first visit to the dentist?________________
If not, how long since the last visit?______________________
Previous Dentist's Name_______________________________
Were any X-Rays taken at previous dental visits?___________
Any injuries to the teeth, face or mouth?_________________
If yes, please explain___________________________________
____
____
Why did you bring the child to the dentist today?__________
____
____
Any other dental concerns or questions you would like answered?____
____
Has the child ever had a serious or difficult problem associated with previous dental work? □ Yes □ No
If yes, please explain___________________________________
____
____

Any of the following habits?

Y N Frequent snacking	Y N Night-time feeding
Y N Lip Sucking / Biting	Y N Nail Biting
Y N Sleeping with a bottle	Y N Thumb/Finger Sucking
Y N Tooth Grinding	Y N Snoring
Y N Sippy Cup Use	Y N Pacifier Use

HOME DENTAL CARE:

Does your child brush his/her own teeth? □ Yes □ No
How often? ________ x a day
Do you brush your child's teeth? □ Yes □ No
How often? ________ x a day
Does the child floss his/her teeth daily? □ Yes □ No
Do you floss his/her teeth? □ Yes □ No
Is your child able to spit? □ Yes □ No

MEDICAL HISTORY:

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding	Y N Disabilities/Special Needs
Y N Allergies to Drugs	Y N Hearing Impairment
Y N Any Hospital Stays	Y N Heart Disease/Murmur
Y N Any Operations	Y N Hemophilia/Blood Disorder
Y N Asthma	Y N Hepatitis
Y N Cancer	Y N HIV + /AIDS
Y N Cong. Birth Defects	Y N Kidney/Liver Conditions
Y N Epilepsy	Y N Rheumatic/Scarlet Fever
Y N Pregnancy	Y N Latex Allergy
Y N Tuberculosis	Y N Diabetes
Y N ADD/ADHD	Y N Autism

Any other serious medical condition?_________________
____
____
Please list all drugs the child is currently taking__________
____
____
Please list all allergies________________________________
____
____

CHILD'S MEDICAL PROVIDER:

Is the child currently under the care of a physician? □ Yes □ No
Physician:____
Physician's Address:_________________________________
____
____
Phone # (_____)____________________________________

Please describe the child's current physical health
GOOD FAIR POOR

ACKNOWLEDGEMENT AND AUTHORITY:

Since the child is a minor, it becomes necessary that signed permission is obtained from a parent or guardian before services can be rendered. I understand that the information I have given is correct to the best of my knowledge, that 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.
I ALSO ACKNOWLEDGE FULL RESPONSIBILITY FOR THE PAYMENT OF SUCH SERVICE AND AGREE TO PAY FOR THEM, IN FULL, AT THE TIME OF SERVICE. I ALSO UNDERSTAND THAT WHERE APPROPRIATE, CREDIT BUREAU REPORTS MAY BE OBTAINED.

____
Signature of Parent or Guardian   Date   Relationship to Child

Who is accompanying the child today? (Relationship) ___________________________________

NOTES:____
____

CHILD'S NAME:_________________________________AGE:______________

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INFORMED CONSENT FOR TREATMENT

Our pediatric dental office philosophy is based on our commitment to preventive dentistry and to creating a supportive and nurturing environment for the children and young adults under our dental care. In particular, we are dedicated to providing a safe, comfortable, and quality dental treatment for all of our patients. Our most important general office policy is to “inform before we perform”.

I hereby authorize Dr. Allan Pang and his staff to perform a clinical examination, take selected diagnostic x-rays, perform a thorough professional cleaning and fluoride treatment. Further, I grant permission for any necessary impressions, study models, photographs or any other diagnostic aids deemed appropriate to make a thorough diagnosis of my child’s dental needs. I also authorize Dr. Allan Pang to perform all recommended and mutually agreed upon treatment, and to use the appropriate medication and therapy in connection with such treatment. These additional procedures may include, but are not limited to, the following: local anesthesia, nitrous oxide-oxygen sedation (“laughing gas”), and dental restorations. A comfortable mouth prop (“tooth pillow”) may be used.

Informed consent indicates your awareness of, and agreement to, the various procedures performed at South Bay Kids Dentistry. You understand that you have the right to ask any questions and we have the obligation to provide you with appropriate answers. It is our intent to provide the best possible dentistry for your child. We will always use warmth, friendliness, persuasion, humor and kindness. There are several other common behavior management techniques that are used by the dentist to protect the safety of your child, to eliminate disruptive behavior and to prevent the child from causing injury to themselves or others due to uncontrolled movements. The following are the techniques commonly used in our practice to sooth and calm an uncooperative patient:

Tell-Show-Do: The dentist and assistant explain to the child what will be done. We use simple terminology and repetition followed by a demonstration with instruments of what is to be done. The procedure will then be attempted on the child’s mouth. Praise is used to reinforce cooperative behaviors.

Positive Reinforcement: These are techniques we use to reward the child for displaying desirable and cooperative behavior. Rewards may include praise, compliments, high-fives, prizes, or stickers.

I hereby acknowledge that I have read and that I understand the consent form. I hereby give authorization and consent to utilize the above techniques listed in conjunction with the treatment listed on my child’s treatment plan.

____
Patient’s Name / Responsible Party Name

______________________________ ____________________
Responsible Party Signature Date

____
Relationship to Patient

Patient Acknowledgement of Receipt of Dental Materials Fact Sheet (DMFS)

______________________________ ____________________
Responsible Party Signature Date