



Image Dental Group

Prashant R. Patel, DDS
7557 El Cajon Blvd Ste A
La Mesa, CA 919141
619-469-4144

www.ImageDentalGroup.com

1

ABOUT YOUR CHILD

Name: _____
Last First M

Nickname: _____

Birth Date: ____/____/____ Male Female

Social Security # : _____

School: _____ Grade: _____

Home Address: _____
Apt #

City State Zip Code

Home Phone: _____

Referred By: _____

2

ABOUT YOU

Your Name: _____
Last First M

Relationship to child: _____

Person Responsible for child: _____

Your home phone and address if different from child's:

Home Address: _____
Apt #

City State Zip Code

Home Phone: _____

Occupation: _____

Employer: _____

Work Phone: _____

3

INSURANCE

DENTAL INSURANCE COMPANY #1

Do you have dental insurance?
Yes No

Group #: _____

This Dental Insurance is provided through:

Their name: _____

Relationship to Child: _____

Their Social Security #: _____

Their Birth Date: _____

Their Employer: _____

DENTAL INSURANCE COMPANY #2

Do you have Secondary dental insurance?
Yes No

Group #: _____

This Dental Insurance is provided through:

Their name: _____

Relationship to Child: _____

Their Social Security #: _____

Their Birth Date: _____

Their Employer: _____

4

MEDICAL/DENTAL HISTORY

Has your child been to the dentist before?

Yes No

If yes, the approximate date of last visit:

Are there any dental problems that you are aware of at present time? Yes No

If yes, please explain: _____

Does your child brush his/her teeth daily?

Yes No

Is your child currently under the care of a physician?

Yes No

Child's Physician: _____

Their Phone #: _____

Is your child allergic to any drugs?

Yes No

If yes, please list: _____

Does your child need to be pre-medicated for artificial joints, heart murmur or mitral valve prolapsed before dental treatment?

Yes No

5

MEDICAL/DENTAL HISTORY

Has your child ever had any of the following medical conditions or problems?

Please Circle

- | | | |
|---|---|-------------------------------|
| Y | N | Heart Murmur |
| Y | N | Heat problems of any kind |
| Y | N | Convulsions/Epilepsy |
| Y | N | Cancer |
| Y | N | Diabetes |
| Y | N | Rheumatic Fever |
| Y | N | HIV + / AIDS |
| Y | N | Hemophilia |
| Y | N | Bleeding problems of any kind |
| Y | N | Hearing Impairment |
| Y | N | Hyperactive |
| Y | N | Any Operations |
| Y | N | Any Stays in Hospital |
| Y | N | Other _____ |

I understand tha the information, that I have givien is corect to the best of my knowledge, that I will be held in the most strict of confidence and it is my responsibility to inform this office of any changes in my child's medical status, I also authrozie the dental staff to perform the necessary dental servies my child may need.

Signature of parent of guardian _____ Date: _____