benjamin c. sun, dds, pllc - 21911 76th Ave West, Suite 203, Edmonds, WA 98026
Phone: (425) 275 – 5155 Fax: (425) 275 – 5174

Welcome

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 you can. 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.

PATIENT INFORMATION

Child's Name: ______________________ Patient goes by: ____________
FIRST MIDDLE INITIAL LAST (If applicable)

Sex: M ☐ F ☐ Birthdate: __________ Age: ______ Home Phone: ____________

Ok to leave message regarding care? Y ☐ N ☐

Address: ______________________
APT/UNIT # CITY/STATE/ZIP

Whom may we thank for referring you? ____________

Notify in case of an emergency (other than parents): ____________ Phone: ____________

Relationship to patient: ____________

PARENTS/GUARDIAN INFORMATION

Father/Guardian name: ____________

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Financially Responsible for patient's account? Y ☐ N ☐

Address (if diff from above): ____________

Mobile phone: ____________

Ok to leave message regarding care? Y ☐ N ☐

Work/other phone: ____________

Ok to leave message regarding care? Y ☐ N ☐

Employer: ____________

Occupation: ____________

SSN: ____________ Birthdate: ____________

Email: ____________

Do you have dental insurance coverage for minor/child? Y ☐ N ☐

If yes, fill out the following:

Insurance Company Name: ____________

Phone Number: ____________

Member ID: ____________ Group ID: ____________

Mother/Guardian name: ____________

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐

Financially Responsible for patient's account? Y ☐ N ☐

Address (if diff from above): ____________

Mobile phone: ____________

Ok to leave message regarding care? Y ☐ N ☐

Work/other phone: ____________

Ok to leave message regarding care? Y ☐ N ☐

Employer: ____________

Occupation: ____________

SSN: ____________ Birthdate: ____________

Email: ____________

Do you have dental insurance coverage for minor/child? Y ☐ N ☐

If yes, fill out the following:

Insurance Company Name: ____________

Phone Number: ____________

Member ID: ____________ Group ID: ____________

DENTAL HISTORY

What would you like us to do for your child today? ____________

Former Dentist: ____________ Phone: ____________

Date of last dental care: ____________ Date of last xray: ____________

How often does your child brush? ____________ Floss? ____________

Does your child experience pain or discomfort in the jaw joint? Y ☐ N ☐

Has your child experienced mouth or chin injury? Y ☐ N ☐

Has your child ever experienced an adverse reaction during or in conjuction with a medical or dental procedure? Y ☐ N ☐

Does your child have speech problems? Y ☐ N ☐

Was your child bottle fed? Y ☐ N ☐

If so, how long? ____________

Does your child suck his/her thumb, fingers or pacifier? Y ☐ N ☐

Is fluoride taken in any form? Y ☐ N ☐

If so, what form? ____________

Other information about your child's dental health or previous treatment: ____________

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Health History

Please answer all questions

Child's Physician: ______________________ Physician's phone #: ______________________

Is child under care of physician now?	Y ☐	N ☐	Has your child received a blood transfusion>	Y ☐	N ☐
Is child receiving any medications or drugs?	Y ☐	N ☐	Has child ever been hospitalized?	Y ☐	N ☐
Is child allergic to any drugs?	Y ☐	N ☐	Are there other allergies: food, pollen, etc?	Y ☐	N ☐
If so, what? ______________			If so, what? ______________		

HAS CHILD HAD HISTORY OR DIFFICULTY WITH ANY OF THE FOLLOWING:

Heart Trouble	Y ☐	N ☐	Cancer	Y ☐	N ☐
Heart Murmur	Y ☐	N ☐	Kidney Disease	Y ☐	N ☐
Anemia	Y ☐	N ☐	Bladder Problems	Y ☐	N ☐
Rheumatic Fever	Y ☐	N ☐	Liver Disease	Y ☐	N ☐
Jaundice	Y ☐	N ☐	Measles	Y ☐	N ☐
AIDS/HIV Positive	Y ☐	N ☐	Cerebral Palsy	Y ☐	N ☐
Bronchitis	Y ☐	N ☐	Mononucleosis	Y ☐	N ☐
Asthma	Y ☐	N ☐	Hearing Trouble	Y ☐	N ☐
Tuberculosis	Y ☐	N ☐	Mumps	Y ☐	N ☐
Diabetes	Y ☐	N ☐	Chicken Pox	Y ☐	N ☐
Epilepsy-Seizures	Y ☐	N ☐	Abnormal Bleeding	Y ☐	N ☐
Joint Replacement	Y ☐	N ☐	Sinus Trouble	Y ☐	N ☐
Learning Disabilities	Y ☐	N ☐	Birth Defects	Y ☐	N ☐
Physical Treatment	Y ☐	N ☐	Attention Deficit Disorder	Y ☐	N ☐
Hepatitis	Y ☐	N ☐	Autism	Y ☐	N ☐
Sickle Cell Anemia	Y ☐	N ☐	Cleft Lip/Palate	Y ☐	N ☐
Down Syndrome	Y ☐	N ☐			

Are there any other conditions other than those listed above that we need to be aware of? ______________________

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AUTHORIZATION

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status; I will inform the dentist.

I authorize the insurance company indicated on this form to pay the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature: ______________________________ Date: ______________

Payment is due in full at time of treatment, unless prior arrangements have been made.