WELCOME TO DR. HORI'S OFFICE **GETTING TO KNOW YOUR CHILD AS OUR PATIENT**

To better serve you, please fill in the following information completely:

PATIENT INFORMATION			
Last Name:	First:		M.I.
Date of Birth: Age:	Nickname:		MALE ☐ FEMALE ☐
Residence Address:			Ph #: ( )
City:	State:	Zip Code:	
Person responsible for payment of account:			Ph #: ( )

QUEST PATIENTS PLEASE COMPLETE THE FOLLOWING			
Subscriber's Name:		Subscriber's ID #:	
FATHER/LEGAL GUARDIAN INFORMATION		**MOTHER/LEGAL GUARDIAN INFORMATION**	
Father's Name:		Mother's Name	
Date of Birth:	Soc Sec #:	Date of Birth:	Soc Sec #:
Occupation:	Email:	Occupation:	Email:
Employer:	Bus. Ph #:	Employer:	Bus. Ph #:
Home Phone #:	Cell Ph #:	Home Phone #:	Cell Ph #:
Is your child covered under your dental plan? Yes ☐ No ☐		Is your child covered under your dental plan? Yes ☐ No ☐	
If Yes: Name of Dental Insurance Membership #: Dental Group or Code: *For office use (effective date):		If Yes: Name of Dental Insurance Membership #: Dental Group or Code: *For office use (effective date):	

Does mother, father and child all live together? Yes ☐ No ☐	
Name of closest relative not living in the same house as patient:	Relationship:
Residence Address:	Phone #: ( )

How did you hear about our Office?
(check only one)

☐ Referred by a friend ☐ Yellow Pages ☐ Relative ☐ Insurance Plan ☐ Mail Flyer ☐ Internet
☐ www.jhoridds.com ☐ Military Guide ☐ Other (please explain):

If you were referred, whom may we thank for referring you?

PATIENT'S MEDICAL HISTORY

Circle Y (Yes) or N (No) as it pertains to your child's medical history:

Y	N	Under medical treatment now	Y	N	Thyroid Disease
Y	N	Hospitalized for surgery or major illness	Y	N	Cancer Chemo/Radiation Therapy
Y	N	Heart Disease or Attack	Y	N	Asthma
Y	N	Stroke	Y	N	Hay-Fever/Allergies or Hives
Y	N	Abnormal Blood pressure (High/Low)	Y	N	Arthritis/Rheumatism
Y	N	Heart Murmur/Mitral Valve Prolapse (MVP)	Y	N	Cortisone Medicine
Y	N	Artificial Heart Valve/Pacemaker/Heart Surgery	Y	N	Epilepsy or Seizure
Y	N	Implant/Artificial Joints (hip, knee, etc.)	Y	N	Ulcers
Y	N	Blood Thinner/Bleeding Disorders	Y	N	Herpes (Cold Sores/Fever Blisters)
Y	N	A.I.D.S. or H.I.V.	Y	N	History of Drug Addiction/Alcohol
Y	N	Immune Suppressed Disorder	Y	N	History of Emotional / Nervous Disorder
Y	N	Hepatitis Type _____	Y	N	History of Psychiatric Emotional Treatment
Y	N	Liver Disease/Jaundice	Y	N	Smoke/Chew Tobacco
Y	N	Diabetes	Y	N	Fainting/Dizziness
Y	N	Tuberculosis (TB) or Lung Disease	Y	N	ADH/ADHD
Y	N	Kidney Trouble	Y	N	Developmental Delay

Is your child allergic to any of the following?

Y	N	Local Anesthetics (Novocaine)	Y	N	Penicillin or other antibiotics	Y	N	Iodine
Y	N	Latex, Metals, Plastics	Y	N	Codeine or other painkillers	Y	N	Other Allergies or Medications
Y	N	Aspirin/Ibuprofen	Y	N	Sulfa Drugs/Sulfites/Sulfides			

If **Yes**, please list: _____

PATIENT'S DENTAL HEALTH

Why has your child come to see us today? (e.g.: pain, checkup, etc.)

Previous Dentist (Optional): Last Visit: Date of Last Cleaning:

Reason(s) for changing dentists:

What problems has your child had with past dental treatment?

Is your child nervous about seeing a dentist? □ Yes □ No If yes please, tell us why:

Circle Y (Yes) or N (No) as it pertains to your child/dental history:

Y	N	I play sports/extracurricular activities.	Y	N	I clench or grind my teeth during the day or while sleeping.
Y	N	I wear a mouth guard.	Y	N	I have problems eating.
Y	N	I am interested in teeth whitening.	Y	N	I have or had pain in my jaw.
Y	N	I am interested in getting braces.	Y	N	My gums feel tender or swollen.
Y	N	I prefer tooth colored fillings.	Y	N	My gums bleed while brushing or flossing.
Y	N	I have had a facial or jaw injury.	Y	N	I eat the daily recommended amount of fruits & vegetables.

What are your dental priorities for your child? (e.g.: appearance, dental health, financial considerations, etc.)

Consent

After explanation by the doctor, I hereby authorize the performance of dental services upon the above named patients and whatever procedures that the judgment of the doctor may dictate in order to carry out these procedures. I understand that my child will come in by themself for treatment. I understand that if my child moves, a clinical assistant will hold their hands. I also understand that if they are very uncooperative, Dr. Hori may be firm with them and use voice control to manage them. I also authorize and request the administration of any anesthetics and x-rays which may be deemed necessary and advisable by the doctor.

_____ _____ _____

(Initial) (Date) Relationship to Patient

Terms and Conditions

This office depends upon reimbursement from the patient for the costs incurred in their care. The financial responsibility of each patient must be determined before treatment. As a condition of treatment by this office, I understand financial arrangements must be made in advance. **All dental service performed without prior financial arrangements, must be paid for at the time services are performed.** I understand that dental services furnished to me are charged directly to me and that I am personally responsible for payment. If I carry insurance, I understand that this office will help prepare my insurance forms to assist in making collections from insurance companies and will credit such collections to my account. However, this dental office cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize release of any information needed and also authorize my insurance company to pay directly to This Office benefits accruing to me under my policy. I understand that the fee estimate listed for this dental care can only be extended for a period of 90 days from the date of the patient's examination. I also understand that in order to collect my debt, my credit history may be checked through the use of my Social Security Number or any other information I have given you. I agree that in the even that either this office of I institute any legal proceedings with respect to amounts owed by me for services rendered, the prevailing party in such proceeding shall be entitled to recover all costs incurred including reasonable attorney's fees. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. I have read the above conditions and agree to their content.

There will be a $50 fee for any missed appointments or appointments not canceled 48 hours before the appointment time

To the best of my knowledge, I have answered every question completely and accurately. I will inform the dentist of any change in my child's health, medication and/or dental needs.

_____ _____ _____

Parent/Guardian's Signature Relationship Date