

# Apple Valley Dental & Orthodontics <sup>TM</sup>

2100 S. 14<sup>th</sup> St. \* Union Gap, WA 98903 \* Telephone (509) - 457-6300  
4309 W. Nob Hill Blvd., Yakima, WA 98908 \* Telephone (509) - 823 - 4480

## Personal Information

What is the reason for your child's Dental Visit? \_\_\_\_\_

Patient's Name \_\_\_\_\_  
*First Middle Initial Last Nickname*

Home Address \_\_\_\_\_  
*Street Apt. # City State ZIP*

Telephone \_\_\_\_\_ E-Mail \_\_\_\_\_  
*Home Work Cell*

Gender M / F (circle one) Birthdate \_\_\_\_\_ Age \_\_\_\_\_ SS# \_\_\_\_\_

Name and ages of other children in family \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_ Phone \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ DOB \_\_\_\_\_ Phone \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ SS# \_\_\_\_\_

Employer \_\_\_\_\_ DOB \_\_\_\_\_ Phone \_\_\_\_\_

Who has legal custody of patient? \_\_\_\_\_ Dental Insurance:  Yes  No

Person responsible for payment of account \_\_\_\_\_

### Primary

### Secondary

Name of Insured	_____	_____
Relationship to Patient	_____	_____
Address	_____	_____
Telephone #	_____	_____
Birthdate/S.S.#	_____	_____
Employer	_____	_____
Dental Ins. Co.	_____	_____
Group #	_____	_____

PERSON TO CONTACT OUTSIDE Name \_\_\_\_\_ Tel. # (\_\_\_\_) \_\_\_\_\_

OF IMMEDIATE FAMILY IN CASE Address \_\_\_\_\_

OF EMERGENCY *Street City State ZIP*

### CONSENT FOR DENTAL TREATMENT

The undersigned hereby authorizes Apple Valley Dental & Orthodontics (AVDO) to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by them to make a thorough diagnosis of the patient's dental needs. I also authorize AVDO to perform any and all forms of treatment, medication and therapy that may be indicated. I understand the use of anesthetic agents embodies a certain risk. I will allow photographs to be taken of my child's mouth or face for diagnostic and educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment appropriate for their developmental age. AVDO will provide an environment likely to help children cooperate during treatment. I also authorize payment directly to the Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all cost of dental treatment and payment is due and payable at the time services are rendered unless financial arrangements have been made. I understand that if financing is required, credit-bureau reports may be obtained. I hereby authorize OrthoBanc, LLC, on behalf of AVDO, to obtain a copy of my credit report from a credit reporting agency for the purpose of considering payment options. (NOTE: *Obtaining an OrthoBanc credit recommendation does not alter the responsible party's credit score in any way.*) I certify the information given on this form is accurate.

### SIGNATURE OF RESPONSIBLE PARTY

\_\_\_\_\_/\_\_\_\_\_  
Guardian Signature Social Security # Date

OVER PLEASE →

**Health History**

- Yes  No Is your child in good health? Name of child's physician \_\_\_\_\_  
 Date of last physical exam \_\_\_\_\_
- Yes  No Has your child ever had a health problem? \_\_\_\_\_
- Yes  No Has your child ever been hospitalized? Please give reason and dates \_\_\_\_\_  
 \_\_\_\_\_
- Yes  No Is your child currently taking any medications/herbs or supplements?  
 Please give name, dose, and reason \_\_\_\_\_  
 \_\_\_\_\_
- Yes  No Does anyone smoke at home?
- Yes  No Were there any problems at birth or prematurity? \_\_\_\_\_
- Yes  No Exposure to Alcohol, Drugs (Illegal), Tobacco? \_\_\_\_\_

Is your child allergic to any of the following?  No

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics

Is he/she allergic to any other medications or substances? \_\_\_\_\_

**GIRLS OVER AGE 10:** Are you -  
 Pregnant/Trying to get pregnant?  Yes  No Taking oral contraceptives?  Yes  No Nursing?  Yes  No  
 (Note: Antibiotics may alter the effectiveness of birth control)

**Please circle if your child has been treated/diagnosed for any of the following:**

<i>Heart disease</i>	<i>Bleeding/transfusions</i>	<i>Asthma/breathing</i>	<i>Accidents/major injury</i>
<i>Liver/GI disease</i>	<i>Digestive problems</i>	<i>Diabetes</i>	<i>Anemia /Blood abnormalities</i>
<i>Kidney disease</i>	<i>Rheumatic fever</i>	<i>Hepatitis</i>	<i>AIDS/HIV</i>
<i>Speech/hearing</i>	<i>Seizures</i>	<i>Cleft lip/palate</i>	<i>Mental delays</i>
<i>Cerebral palsy</i>	<i>Congenital birth defects</i>	<i>Personality/social</i>	<i>Physical delays</i>
<i>Cancer/tumors</i>	<i>Recurrent headaches</i>	<i>Frequent infections</i>	<i>Abnormal drug reaction</i>
<i>Eyesight</i>	<i>Endocrine/growth</i>	<i>Tonsils/Adenoids</i>	<i>Pregnancy</i>

Please explain any circled items or other problems: \_\_\_\_\_

Do you consider your child to be:  advanced in learning  progressing normally  slow in learning

Was your child:  breast fed  bottle fed  sippy cup Age it was stopped? \_\_\_\_\_

**Dental History**

- Yes  No Has your child ever been to the dentist? Name of dentist and date \_\_\_\_\_
- Yes  No Has your child experienced any unfavorable reaction from previous dental care? Explain: \_\_\_\_\_
- Yes  No Does your child suck a finger(s), thumb or pacifier?
- Yes  No Does your child grind teeth, bite nails or snore?
- Yes  No Does your child have pain with chewing, yawning, or wide opening?
- Yes  No Does your child's jaw make noise and is pain associated with the sounds?

**Please circle if your child is having problems or involved with any of the following:**

<i>Cavities</i>	<i>Bad breath</i>	<i>Sports</i>	<i>Teeth sensitive/Pain</i>
<i>Trauma</i>	<i>Lip blisters</i>	<i>Gum infections</i>	<i>Color of teeth</i>
<i>Orthodontics</i>	<i>Jaw sounds</i>	<i>Missing or extra teeth</i>	<i>Other</i>

Comments: \_\_\_\_\_

**Fluoride History**

- Yes  No Is your home water supply fluoridated?
- Yes  No Does your child use a fluoride toothpaste?
- Yes  No Does your child receive any other form of fluoride? What? \_\_\_\_\_
- Yes  No Does your child participate in a school/physician fluoride program?

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_

Have there been any changes in the above since your last visit?

Yes  No Signature: \_\_\_\_\_ Dentist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Yes  No Signature: \_\_\_\_\_ Dentist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness Signature: \_\_\_\_\_ Date: \_\_\_\_\_