**Peninsula Pediatric Dentistry,**
**Dental Office of Brian C. Quo, PC**
**882-A Emerson St.**
**Palo Alto, CA 94301**
**(650) 853-8883**

**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 any questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.**

Date: _____

Name of Minor/Child: _____
First Name Middle Initial Last Name

Nickname: _____ Birth date: _____ Sex: M F Age: _____

Home Address: _____
Street City State Zip

Mailing Address: _____
(if different from above) Street City State Zip

Person Financially Responsible (Name of Insured): _____

**Cell Number:** (_____) _____ Secondary Number: (_____) _____

Whom may we thank for referring you? _____

Fathers/Guardian's Name: _____

Address (if different from patient's) _____

_____

**Cell Phone:** (_____) _____
(if different from above)

**E-Mail:** _____

Soc. Sec. #: _____ D.O.B.: _____

Employer: _____

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

Plan Name: _____ Phone: (____) _____

Address: _____

_____

ID #: _____

Group #: _____

Mother's/Guardian's Name: _____

Address (if different from patient's) _____

_____

**Cell Phone:** (_____) _____
(if different from above)

**E-Mail:** _____

Soc. Sec. #: _____ D.O.B.: _____

Employer: _____

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

Plan Name: _____ Phone: (____) _____

Address: _____

_____

ID #: _____

Group #: _____

***Please Complete Both Sides***

Date of last visit to a dentist: _____ For what service? _____

Has child complained about dental problems? ... Y N

Is fluoride taken in any form? ……... Y N

Does child brush teeth daily? ……..…… Y N

Any injuries to mouth, teeth, head? ……..... Y N

Does child floss every day? …… Y N

Any unhappy dental experiences ……...……. Y N

Any mouth habits – thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc.? ……..….... Y N

**Is Minor/Child under care of physician right now?** Y N

Minor/Child's Physician: _____ City/State: _____ Phone: (____) _____

Date of last physical examination: _____ Results: _____

**Medications:** _____

**Allergies:** _____

Ever had surgery? ……..……..…….. Y N

Receiving any medications or drugs? ….…...…… Y N

Ever been hospitalized? ……..……..…. Y N

Is there excessive bleeding when cut? ……... Y N

Has minor/child had any history of or difficulty with any of the following? **Please circle YES or NO:**

| | | |
|---|---|---|
| Y N A.I.D.S./H.I.V. | Y N Convulsions | Y N Measles |
| Y N Anemia | Y N Developmental Delay | Y N Mononucleosis |
| Y N Asthma | Y N Diabetes | Y N Mumps |
| Y N Autism | Y N Epilepsy/Seizures | Y N Rheumatic Fever |
| Y N Bladder Problems | Y N Hearing Problems | Y N Sinus Problems |
| Y N Cancer | Y N Heart Problems | Y N Thyroid Disease |
| Y N Cerebral Palsy | Y N Hepatitis | Y N Tuberculosis |
| Y N Chicken Pox | Y N Kidney/ Liver Disease | Y N Other |

**In the event of an emergency, whom should we contact?**

Name: _____ Relationship: _____ Phone: (_____) _____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform the doctor if my minor/child ever has a change in health.

**Minor/Child Consent**

I am the parent, guardian, or personal representative of _____ and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when treatment is rendered.

**Insurance Assignment and Release**

I certify that my dependent(s) is covered by insurance with _____ and assign directly to
Name of Insurance Company(ies)

Dr. Brian C. Quo, DDS, MS all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

Dr. Brian C. Quo, DDS, MS may use my minor's/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits of the benefits payable for related services.

_____ _____
Signature of Parent, Guardian, or Personal Representative Date

_____ _____
Please print name of Parent, Guardian, or Personal Representative Relationship to Patient