tpdo
Torrance Pediatric
Dentistry & Orthodontics

Sepideh Ariarad, DDS, MS
Orthodontist

Richard Spaulding, DDS
Pediatric Dentist

NEW PATIENT INFORMATION

CHILD'S INFORMATION

Child's Name _____

Child's Nickname _____ ◯ Male ◯ Female

Birthday _____ Age _____

Home Address _____

City _____ State _____ Zip _____

School _____ Grade _____

Referred to Our Office by _____

PARENT INFORMATION

Relationship _____

Parent #1 Name _____

Address _____

City _____ State _____ Zip _____

Home Number _____ Cell _____

E-mail Address _____

Occupation/Employer _____

Work Number _____

Relationship _____

Parent #2 Name _____

Address _____

City _____ State _____ Zip _____

Home Number _____ Cell _____

E-mail Address _____

Occupation/Employer _____

Work Number _____

Name of close friend/relative _____

Phone _____

Does the patient have any siblings? ◯ Yes ◯ No

If yes, name child's siblings and their ages: _____

_____

_____

INSURANCE INFORMATION

Is your child covered by a dental plan? ◯ Yes ◯ No

If so, whose plan is the child covered? _____

Name of parent insured _____

Insurance Carrier _____

Insurance Phone _____

Group/Policy # _____

Name of parent insured _____

Insurance Carrier _____

Insurance Phone _____

Group/Policy # _____

Is your child covered by a medical plan? ◯ Yes ◯ No

If so, whose plan is the child covered? _____

Name of parent insured _____

Insurance Carrier _____

Insurance Phone _____

Group/Policy # _____

Name of parent insured _____

Insurance Carrier _____

Insurance Phone _____

Group/Policy # _____

CHILD'S PHYSICIAN

Name _____ City _____

Phone _____ Last visit _____

SOCIAL AND BEHAVIOR

Has your child had a previous unfavorable or fearful dental or medical experience? ◯ Yes ◯ No

If yes, please describe _____

How would you best describe your child's temperament? _____

What is your child's favorite color/toy/movie? _____

phone: 310.792.6262
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Torrance, California
90503

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NEW PATIENT INFORMATION CONTINUED

MEDICAL HISTORY

Was your child born prematurely? ◯ Yes ◯ No

Has your child ever been hospitalized or undergone any surgeries? ◯ Yes ◯ No

Is your child handicapped or disabled in any way? ◯ Yes ◯ No

Are your child's immunizations current? ◯ Yes ◯ No

Current medications _____

Current allergies _____

Has your child been diagnosed and/or treated for any of the following?

Abnormal Bleeding ◯ Yes ◯ No
AIDS/HIV ◯ Yes ◯ No
Anemia ◯ Yes ◯ No
Asthma ◯ Yes ◯ No
Blood Transfusion ◯ Yes ◯ No
Cancer ◯ Yes ◯ No
Cerebral Palsy ◯ Yes ◯ No
Cleft Palate/Lip ◯ Yes ◯ No
Diabetes-Type _____ ◯ Yes ◯ No
Epilepsy ◯ Yes ◯ No
Hearing/Speech ◯ Yes ◯ No
Heart Disease ◯ Yes ◯ No
Heart Murmur ◯ Yes ◯ No
Hemophilia- Type _____ ◯ Yes ◯ No
Hepatitis- Type _____ ◯ Yes ◯ No
High/Low Blood Pressure ◯ Yes ◯ No
Hives ◯ Yes ◯ No
Kidney Problems ◯ Yes ◯ No
Liver Problems ◯ Yes ◯ No
Rheumatic Fever ◯ Yes ◯ No
Sickle Cell Anemia ◯ Yes ◯ No
Tuberculosis (TB) ◯ Yes ◯ No

ADOLESCENT WOMEN:

Pregnant Now or Might be ◯ Yes ◯ No
Taking Birth Control Pills ◯ Yes ◯ No

DENTAL HISTORY

Child's First Dental Visit ◯ Yes ◯ No

Date of Last Dental Visit _____

Previous Dentist _____

How can we help make this a positive visit for your child? _____

Has the child suffered any injuries to the teeth, mouth or jaws? ◯ Yes ◯ No

Does your child have any of the following habits?

◯ Thumb/Finger Sucking ◯ Grinding/Clenching Teeth
◯ Lip Sucking/Biting ◯ Mouth Breathing
◯ Pacifier Use

Breast Feeding ◯ Yes ◯ No Age Stopped? _____

Bottle Feeding ◯ Yes ◯ No Age Stopped? _____

How often does your child brush? _____

Is brushing assisted by an adult? ◯ Yes ◯ No

Is dental floss used? ◯ Yes ◯ No

Does your child receive:

Fluoride toothpaste ◯ Yes ◯ No
Fluoride-free toothpaste ◯ Yes ◯ No
Tap water ◯ Yes ◯ No
Water from reverse osmosis ◯ Yes ◯ No
Fluoride supplements ◯ Yes ◯ No

Anything else you wish to bring to the Doctor's attention? _____

I hereby authorize Dr. Richard A Spaulding, DDS and/or Dr. Sepideh Ariarad, DDS, MS to perform any and all treatment for my above named child and consent to such methods, drugs, and agents as may be indicated in connection with his/her dental care. This consent shall remain in effect until canceled. PLEASE NOTE: Payment is expected for service rendered at the time of each visit. Financial arrangements may be made following the diagnosis. A 1.5% monthly finance charge is added to all amounts after 90 days. This represents an annual percentage charge of 18%.

Signature of Parent/Legal Guardian (below)

_____

Relationship to Patient _____

Date _____

Signature of Doctor (below)

_____

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