Coconut Kids
Dentistry & Orthodontics

Braces By GRANT

Peggy Lundquist DDS
Angela Lee DMD
Richard Grant DDS, MS
James Grant DDS, MS

12395 El Camino Real, Ste. 218 San Diego, CA 92130
Phone: (858) 755-1515
Email: info@cocokidsdo.com

We are pleased to welcome you 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 creating your beautiful smile!

Patient Information

Name: _____ Date of Birth: _____/_____/_____Age:____
Nickname: _____Male: _____Female: _____Social Security: _____-_____-_____
Address: _____City: _____State: _____Zip: _____
Home Telephone: _____-_____-_____ Whom May We Thank For Your Referral: _____
Patient's Dentist:_____ Last Check-up/Cleaning: _____/_____/_____
Best Email**:** _____ Patient's School: _____

Responsible Party Information

Mother/Guardian Name: _____Date of Birth: _____/_____/_____
Social Security: _____-_____-_____ Employer: _____
Address: _____City: _____State: _____Zip: _____
Home Telephone: _____-_____-_____ Work: _____-_____-_____ Cell: _____-_____-_____
Father/Guardian Name: _____ Date of Birth: ____/_____/_____
Social Security: _____-_____-_____ Employer: _____
Address: _____City: _____State: _____Zip: _____
Home Telephone: _____-_____-_____ Work: _____-_____-_____ Cell: _____-_____-_____

Primary Insurance Coverage

Primary Insured Name: _____ Date of Birth: _____/_____/_____
Relationship to Patient: _____Social Security: _____-_____-_____
Employer: _____ Address: _____
Name of Insurance: _____Group Number:_____
Address: _____ Telephone: _____-_____-_____

Secondary Insurance Coverage

Secondary Insured Name: _____Date of Birth: _____/_____/_____
Relationship of Patient: _____Social Security: _____-_____-_____
Employer: _____ Address: _____
Name of Insurance: _____ Group Number: _____
Address: _____ Telephone: _____-_____-_____

Health History

Personal

Patient's Name: _____ Date of Birth: _____/_____/_____Age:_____

Purpose of today's dental or orthodontic examination: _____

Is your child adopted? ☐ Yes ☐ No *If yes, does your child know?* _____

Child's Dental History

Has your child seen a dentist before? ☐ Yes ☐ No *If yes, date of last visit* _____

How often does your child brush his/her teeth? _____ Do you help? ☐ Yes ☐ No

How often does your child floss? _____ Do you help? ☐ Yes ☐ No

Medical History

☐ Yes ☐ No AIDS/HIV	☐ Yes ☐ No Cleft Lip/Palate	☐ Yes ☐ No Kidney Disease
☐ Yes ☐ No Allergies to latex	☐ Yes ☐ No Developmental Delay	☐ Yes ☐ No Liver Disease
☐ Yes ☐ No Anemia	☐ Yes ☐ No Diabetes	☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No ADD/ADHD	☐ Yes ☐ No Epilepsy	☐ Yes ☐ No Sinus Problems
☐ Yes ☐ No Bladder Problems	☐ Yes ☐ No Heart Problems	☐ Yes ☐ No Thyroid Disease
☐ Yes ☐ No Blood Disorders	☐ Yes ☐ No Hepatitis	☐ Yes ☐ No Migraines
☐ Yes ☐ No Cerebral Palsy	☐ Yes ☐ No Jaundice	☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Premature	☐ Yes ☐ No Stomach Problems	☐ Yes ☐ No Cancer
☐ Yes ☐ No Hospital operations	☐ Yes ☐ No Canker or Cold Sores	☐ Yes ☐ No Radiation
☐ Yes ☐ No High Blood Pressure	☐ Yes ☐ No Eye Disease	☐ Yes ☐ No Chemotherapy
☐ Yes ☐ No Osteoporosis	☐ Yes ☐ No Asthma	☐ Yes ☐ No Depression/Anxiety

Other: _____

- Physicians Name: _____
- Is patient under care of physician now ☐ Yes ☐ No *If yes, why* _____
- Has patient ever been hospitalized ☐ Yes ☐ No *If yes, why* _____
- Has patient ever had surgery ☐ Yes ☐ No *If yes, why* _____
- (Women) Are you pregnant ☐ Yes ☐ No Nursing ☐ Yes ☐ No Taking birth control pills ☐ Yes ☐ No
- Has Patient reached Puberty ☐ Yes ☐ No **Girl** started menstruation ☐ Yes ☐ No **Boy** has voice changed ☐ Yes ☐No
- Is your child currently taking any medication? ☐ Yes ☐ No *If yes, list names and purposes*
  _____
- Does your child have any breathing problems? ☐ Yes ☐ No *If yes, please explain:*_____
- Breathes primarily through: ____Nose ____Mouth Do you snore? ☐ Yes ☐ No
- Are you taking any supplemental fluoride? ☐ **No** Tablets _____ Drops _____ Water _____ Vitamins _____

Allergic or reactions to any of the following? ☐ NONE

☐ Aspirin	☐ Darvon	☐ Latex	☐ Penicillin
☐ Antibiotics	☐ Demerol	☐ Local Anesthetics	☐ Percodan
☐ Barbiturate Sedatives	☐ Erythromycin	☐ Metal	☐ Tetracycline
☐ Codeine	☐ Foods	☐ Nitrous Oxide	☐ Vicodin

Other: _____

Habits

☐ Yes ☐ No Did your child use a bottle? *If yes, when did child stop?* _____

☐ Yes ☐ No Does your child currently use a bottle? *If yes, when did child stop?* _____

☐ Yes ☐ No Sucks thumb/finger ☐ Yes ☐ No Nail biting ☐ Yes ☐ No Teeth grinding

☐ Yes ☐ No Pacifier use ☐ Yes ☐ No Biting or sucking lip

Family Dental History ☐ NONE

☐ Father ☐ Mother Had a lot of decay ☐ Father ☐ Mother Had orthodontic care

☐ Father ☐ Mother Have periodontal disease ☐ Father ☐ Mother Have TMJ problems

Authorization

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my/my child's medical status. I authorize the dental/orthodontic staff to perform the necessary dental/orthodontic services for me/my child. I certify that the patient is covered by insurance with: _____. I assign directly to Coconut Kids Dentistry & Orthodontics / Braces by Grant 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 also understand that responsibility for payment for dental/orthodontic services provided in the office for me/my child is mine, due and payable at the time services are rendered unless financial arrangements have been made IN ADVANCE. I hereby authorize Coconut Kids Dentistry & Orthodontics / Braces by Grant, to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions, whether manual or electronic. I further understand that it is my responsibility to inform this office of any changes in my/my child's insurance coverage.

Signature: _____Date: _____/_____/_____

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
2. Obtaining payment from third payers (e.g. my insurance company)
3. The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used an disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date _____

Print Patient Name: _____

Relationship to Patient: _____

Print Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____