Bethel Kids DENTAL

531 W. Kettleman Lane
Lodi, CA 95240
Tel: 209-400-2018

1660 W. Yosemite Ave. #1
Manteca, CA 95337
Tel: 209-500-1910

3633 Bradshaw Rd. #A
Sacramento, CA 95827
Tel: 916-810-2025

RETURNING PATIENT FORM

Patient Name (First and Last Name): _____ Date: _____

Phone: _____ 2nd Phone: _____Email: _____

Any changes to home address? If yes, please list new address below:

_____

Do you have a new dental insurance? If yes, please list Name and ID # below:

_____

Please check any dental concerns:

◯ Cavities ◯ Color of Teeth ◯ Grinding of Teeth ◯ Gum Infections
◯ Jaw Sounds ◯ Mouth Breathing ◯ Orthodontics ◯ Sensitive Teeth
◯ Toothache ◯ Trauma ◯ Dental Pain ◯ None
◯ Other: _____

Have there any been changes in your child's medical history? ◯ Yes ◯ No
If yes: _____

Is your child currently taking any medications? ◯ Yes ◯ No
If yes, please list: _____

Any hospitalization or surgery since your child's last visit? ◯ Yes ◯ No

Is your child allergic to any food or medication? ◯ Yes ◯ No
If yes, please list: _____

Does your child begin to smoke cigarettes or use any tobacco products? ◯ Yes ◯ No
If yes, when and what products? _____

APPOINTMENT CANCELLATION AND NO-SHOW POLICY

At Bethel Kids Dental, we are dedicated to providing timely and high-quality care for all our patients. Missed appointments or last-minute cancellations disrupt our schedule and prevent other patients from receiving necessary treatment. Therefore, we require at least 24 hours' advance notice if you need to cancel or reschedule an appointment. Failure to provide timely notice may result in consequences for future scheduling. **Patients who miss three appointments without proper notice will lose the privilege of scheduling future appointments.** Additionally, depending on your insurance provider, a missed appointment fee may be applied. Please check with your insurance company for details on potential charges. We prepare in advance for every appointment by reserving a treatment room, preparing records, and readying necessary instruments. We expect the same level of commitment from our patients. If you are unable to keep your appointment, please contact us as soon as possible at (209) 400-2018. We will be happy to assist in rescheduling to a more suitable time.

I certify that I have read and understand the contents of this form. I will not hold Bethel Kids Dental, doctors, and staff, responsible for any action they take or do not take because of errors or omissions that I have made in completing this form. I will notify Bethel Kids Dental any changes on my child's information, and health.

Print: _____ **Signature:**_____ **Date:** _____

Bethel Kids DENTAL

531 W. Kettleman Lane
Lodi, CA 95240
Tel: 209-400-2018

1660 W. Yosemite Ave. #1
Manteca, CA 95337
Tel: 209-500-1910

3633 Bradshaw Rd. #A
Sacramento, CA 95827
Tel: 916-810-2025

HEALTH HISTORY FORM

Dental History

◯Yes ◯No Has your child ever been to the dentist? Date of last cleaning & x-rays (if taken) _____
◯Yes ◯No Has your child experienced any unfavorable reaction from previous dental care? If yes, please explain: _____
◯Yes ◯No Does your child suck a finger, thumb, or pacifier (please circle)? If yes, when? _____
◯Yes ◯No Does your child go to bed with a bottle or sippy cup? If yes, what is in it? _____
◯Yes ◯No Does your child snack frequently? What are their favorite snack foods? _____
◯Yes ◯No Has your child had local anesthetic? If yes, were there any problems? _____
◯Yes ◯No Has your child ever been sedated for dental treatment? If yes were there any problems?_____
_____
◯Yes ◯No Have your child's teeth ever been injured? Which teeth: _____
◯Yes ◯No Has your child or anyone in your immediate family ever had a cold sore or other mouth ulcer? Please describe: _____
◯Yes ◯No Does your child use a fluoride toothpaste?
◯Yes ◯No Does your child begin to smoke cigarettes or use any tobacco products?

Medical History

Child's Physician/Pediatrician: _____ Phone: _____
◯Yes ◯No Is your child in good health? Date of last physical exam: _____
◯Yes ◯No Has your child ever had a health problem? _____
◯Yes ◯No Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Please explain: _____
◯Yes ◯No Is your child currently taking any medications? Please give medication, dose, and reason: _____
◯Yes ◯No Is your child allergic to any medications? Any food? If yes, please list what medication and/or food: _____
_____
◯Yes ◯No Are your child's immunizations current?
◯Yes ◯No Have you ever been told that your child needs to take antibiotics before dental treatment?

Please check if your child has been treated for any of the following:

◯Abuse
◯ADHD
◯Adverse Drug Reaction
◯Anemia
◯Asthma/Breathing Problems
◯Autism
◯Blood Transfusion
◯Blood Disorders
◯Cancers/Tumors
◯Cerebral Palsy
◯Congenital Birth Defect
◯Diabetes
◯Endocrine/Growth Problems
◯Eyesight Problems
◯Frequent Infections
◯Heart Disease
◯Heart Murmurs
◯Hepatitis
◯HIV/AIDS
◯Liver/GI Disease
◯Mental Delays
◯Personality Problems
◯Recurrent Headaches
◯Seizures
◯Sickle Cell Disease
◯Significant Injuries
◯Snoring
◯Speech/Hearing Issues
◯Spina Bifida
◯Tonsil Problems
◯Tuberculosis

Other: _____

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 child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

Patient Name: _____

Parent/Guardian Signature: _____ **Date:** _____