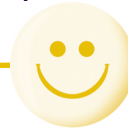
B. Scott Hood, D.D.S., M.S., Inc.

WELCOME



Chico Office:
2755 Esplanade
Chico, CA 95973
Phone: (530) 343-7021

Paradise Office:
5657 Clark Road #5
Paradise, CA 95969
Phone: (530) 877-4951

The benefits of a happy, healthy smile are immeasurable!
We would like to welcome you and your child to our office. Please fill out this form completely.
The better we communicate, the better we can care for your child.

1 TELL US ABOUT YOUR CHILD

Name ______________________________

Preferred Name ____________________ ❑ Male ❑ Female

Birthdate ___/___/___ Age ____ SS# ____ - ____ - ______

Address ______________________________

City ________________ State __________ Zip ______

Home Phone # ______________________________

School ________________ Grade ______________

Hobbies / Sports ______________________________

2 WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name ________________ Relation __________

Do you have legal custody of this child? ❑ Yes ❑ No

List brothers/sisters and ages: ______________

General Dentist: ______________________

Last Visit Date: ______________________

Parents' Marital Status: ❑ Single ❑ Widowed ❑ Married ❑ Divorced ❑ Separated

3a PARENT INFORMATION

❑ **MOTHER'S INFORMATION** ❑ Step Mother ❑ Guardian

Name ______________________________

Address ______________________________

Home # ________________ Work # ______________

Cell # ________________ Birthdate ____/____/____

Employer ______________________________

❑ **FATHER'S INFORMATION** ❑ Step Father ❑ Guardian

Name ______________________________

Address ______________________________

Home # ________________ Work # ______________

Cell # ________________ Birthdate ____/____/____

Employer ______________________________

3b PERSON RESPONSIBLE FOR ACCOUNT

Name ________________ Relation __________

Billing Address ______________________________

City ________________ State ________ Zip ______

Home # ______________ DL # ______________

Email ______________________________

Employer ______________________________

Work # ____________ Ext ______ SS # ____________

4 PRIMARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name ______________________

Insurance Co. Address ______________________

Insurance Co. Phone # ______________________

Group # (Plan, Local, or Policy #) ______________

Policy Owner's Name ______________________

Relationship to Patient ______________________

Policy Owner's Birth Date ________ SS # ____________

Policy Owner's Employer ______________________

SECONDARY ORTHODONTIC INSURANCE

Orthodontic Coverage? ❑ Yes ❑ No

Insurance Co. Name ______________________

Insurance Co. Address ______________________

Insurance Co. Phone # ______________________

Group # (Plan, Local, or Policy #) ______________

Policy Owner's Name ______________________

Relationship to Patient ______________________

Policy Owner's Birth Date ________ SS # ____________

Policy Owner's Employer ______________________

Continued on Back

5 REASON FOR TREATMENT

What are the main concerns that you would like orthodontics to address? ______________________

Has your child ever been evaluated for or had orthodontic treatment before? ❑ Yes ❑ No

Have there been any injuries to the face, mouth, teeth or chin? ❑ Yes ❑ No

List any musical instruments played: ______________

Have adenoids or tonsils been removed? ❑ Yes ❑ No

Has your child been informed of any missing or extra permanent teeth? ❑ Yes ❑ No

Has your child ever had any pain or tenderness in his/her jaw joint? (TMJ/TMD) ❑ Yes ❑ No

Does your child brush his/her teeth daily? ❑ Yes ❑ No

Floss his/her teeth daily? ❑ Yes ❑ No

Child's Physician: ______________________

Phone: ______________ Date of last visit: ________

Is your child currently under the care of a physician? ❑ Yes ❑ No

Has puberty begun? ❑ Yes ❑ No

Has menstruation begun? (Girls) ❑ Yes ❑ No

Please describe your child's current physical health:

❑ Good ❑ Fair ❑ Poor

Please list other medical condition(s) that they have ever had:

____

Please list ALL drugs OR materials that they are allergic to:

____

6 MEDICAL / DENTAL HISTORY

Has your doctor told you that your child requires antibiotics before dental treatment? ❑ Yes ❑ No

Is your child currently in pain? ❑ Yes ❑ No

Have they ever had a serious / difficult problem associated with any previous dental work? ❑ Yes ❑ No

Abnormal Bleeding?	❑ Yes	❑ No	Diabetes?	❑ Yes	❑ No
Allergy to Any Drugs?	❑ Yes	❑ No	Handicaps / Disabilities?	❑ Yes	❑ No
Allergy to Latex / Metals?	❑ Yes	❑ No	Hearing Impairment?	❑ Yes	❑ No
Allergy to Any Plastics?	❑ Yes	❑ No	Heart Murmur?	❑ Yes	❑ No
Any Hospital Stays?	❑ Yes	❑ No	Hemophilia?	❑ Yes	❑ No
Any Operations?	❑ Yes	❑ No	Hepatitis?	❑ Yes	❑ No
Asthma?	❑ Yes	❑ No	HIV+ / AIDS?	❑ Yes	❑ No
Cancer?	❑ Yes	❑ No	Kidney / Liver Problems?	❑ Yes	❑ No
Congenital Heart Defect?	❑ Yes	❑ No	Rheumatic / Scarlet Fever?	❑ Yes	❑ No
Convulsions / Epilepsy?	❑ Yes	❑ No	Tuberculosis (TB)?	❑ Yes	❑ No

Please discuss any medical problems that your child has had:

____

7 DISCLAIMER

I understand that information I have given today is correct to the best of my knowledge. I also understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office.

Signature ______________________ Date ________

THE PARENT OR GUARDIAN WHO ACCOMPANIES THE CHILD IS RESPONSIBLE FOR PAYMENT. PAYMENT IS DUE IN FULL AT THE TIME OF TREATMENT UNLESS OTHER ARRANGEMENTS HAVE BEEN APPROVED.

B. Scott Hood, D.D.S., M.S., Inc.

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

OFFICE USE ONLY

I have verbally reviewed the medical / dental information above with the patient named herein: Initials ________ Date ________

Doctor's comments: ______________________