Allan P. Capinpin, D.D.S.

MINOR/STUDENT AGE MINOR-PATIENT INFORMATION

Today's Date_____ **Home Phone( )**_____
Cell Phone ( )_____
☐ **Text to cell is ok**

Name_____ **Birth date**_____/_____/_____ **Age**_____

Address_____ _____
City **State** **Zip**

School name_____ _____
City **State**

PARENTS INFORMATION

Father's (guardian) Name_____ **Resides with?** _____
Birthdate ____/____/_____ **SS#** _____ **Employer** _____
PHONE: Home_____ **Work** _____ **Cell** _____

Mother's (guardian) Name_____ **Resides with?** _____
Birthdate ____/____/_____ **SS#** _____ **Employer** _____
PHONE: Home_____ **Work** _____ **Cell** _____

As a courtesy service to our patients, we will bill your insurance company, as long as you have provided all necessary information. Your insurance policy is a contract between you, your employer and the insurance company. Insurance policies vary and services provided may not be covered. We cannot guarantee insurance payment, as the insurance carrier will not guarantee payment before a claim is received. Please contact your employer or insurance carrier if you have questions about your policy coverage.

PRIMARY CARRIER

(The insured parent with the closest birth month to January, is primary, unless, under court order. Please contact your provider)

Insurance Company_____
ID/MEMBER #_____
Group #_____
Relationship to patient: Mom Dad Self

SECONDARY CARRIER

Insurance Company_____
ID/MEMBER #_____
Group #_____
Relationship to patient: Mom Dad Self

I, the undersigned certify that I (or my dependant) have insurance coverage with _____**and assign directly to Dr. Capinpin 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 hereby authorize Dr. Capinpin to release all information necessary to secure the payment of benefits; I authorize the use of this signature on all insurance submissions.**

_____
Responsible Party Signature **Relationship** **Date**

GENERAL INFORMATION

Whom may we thank for referring you?_____**Relationship**_____

Contact in case of emergency_____**Phone( )**_____

CONSENT FOR DENTAL TREATMENT

I hereby give consent to any advisable and necessary dental procedures, medications, anesthetics or necessary radiographs (x-rays), to be administered by Dr. Allan Capinpin or the supervised licensed staff for diagnosis and treatment of my child's dental condition.

_____ _____
Parent/Guardian Signature **Date**

Patients Name:

MINOR/STUDENT AGE MINOR PATIENT-MEDICAL HISTORY

Physician's Name_____ Kaiser ID#_____ Phone ( )_____
Has he/she been under the care of a medical doctor during the past two years? ..... Yes No
If yes, for what_____
Has he/she been a patient in the hospital during the past five years? ..... Yes No
If yes, for what_____

Due to constant changes in the medical and dental health fields it is very important of Dr. Capinpin to know about your child's over all health. **Please circle "yes" or "no" if he/she have or have had any of the following:**

yes no **Anemia**
yes no **Angina Pectoris**
yes no **Arthritis/Rheumatism**
yes no **Artificial Heart Valve**
yes no **Artificial Joints (hip, knee)**
yes no **Asthma**
yes no **Back Problems**
yes no **Blood Transfusion**
yes no **BRONJ**
yes no **Bruise Easily**
yes no **Cancer**
yes no **Chemotherapy**
yes no **Chest Pain**
yes no **Chronic Cough**
yes no **Cold Sores/Fever Blisters**
yes no **Congenital Heart Disease**
yes no **Contact Lens**
yes no **Cortisone Treatments**
yes no **Diet (special, restricted)**
yes no **Diabetes**
yes no **Eating Disorders**
yes no **Emphysema**
yes no **Epilepsy/Seizures**
yes no **Fainting/Dizzy Spells**
yes no **Glaucoma**
yes no **Headaches**
yes no **Heart Disorder**
yes no **Heart Infection**
yes no **Heart Valve Replacement**
yes no **High Blood Pressure**
yes no **Heart Pacemaker**
yes no **Hay Fever**
yes no **Hepatitis (a, b, c)**
yes no **Hemophilia**
yes no **H.I.V/A.I.D.S**
yes no **Kidney Trouble**
yes no **Liver Disease**
yes no **Nervous/Anxious**
yes no **Neurological Disorders**
yes no **Psychiatric Care**
yes no **Psychological Care**
yes no **Radiation Therapy**
yes no **Swollen Ankles**
yes no **S.T.D.**
yes no **Stroke**
yes no **Sinus Trouble**
yes no **Sickle Cell Disease**
yes no **Thyroid (high, low)**
yes no **Tuberculosis**
yes no **Tumors**
yes no **Ulcers**
yes no **Yellow Jaundice**

Any Other Condition not listed? _____

MEDICATIONS

List medications you are currently taking _____
_____
List herbal remedies or vitamins you take_____
_____

ALLERGIES

Are you aware of having an allergic (or adverse reaction) to any medications or substance? _____
If yes, please list _____
_____

WOMEN

Are you: Pregnant? .....Yes (months_____) Nursing? ..... Yes No
Taking Birth control Pills? ..... Yes No

I understand the above information is necessary to provide the minor child or myself with dental care in a safe and efficient manner. I have answered all questions to the best of my knowledge.

I understand that it is my responsibility to inform the doctor if there is ever a change in health or medication.

_____ _____
Parent/Guardian Signature **Date**

Dr. Capinpin has reviewed the above Health History with the patient/guardian.

_____ _____
Signature **Date**