Welcome

to the office of

Frank J. Sierra, DMD, PA

SIERRA Pediatric Dentistry & Laser Center

We would like to welcome you and your child to our office. Our practice goal is to improve the lives of children by optimizing their oral health which will benefit their overall wellness. We will accomplish this state of the art treatment with a friendly approach focusing on the child's special needs.

Patient Information

Name: _____

Nickname: _____

Date of Birth: _____ Male___ Female___

Social Security #_____

Home Address:_____

_____

Parent/Guardian Information

Name: _____

Relationship to patient:_____

Home Address (if different):_____

_____

Phone numbers: Home:_____ Work: _____ Mobile: _____

Email address: _____

Dental Insurance Information

Insurance Company Name: _____ Group# _____

Insurance Company Phone: _____

Insured Name: _____ Relationship to patient:_____

Insured SSN: _____ Insured Date of Birth:_____

Insured Employer:_____

Referred By: _____

Previous Consultations Yes No Dr._____

Medical History

( ) Full Term Birth or ( )Premature Birth _____ weeks
Any birth complications? ( )No ( )Yes: _____
Any medical issues after birth? ( )No ( )Yes:_____
Hospital/Birthing Center/Home birth:_____
Birth Weight: _____ Current Weight: _____

Breast Feeding ( )yes ( )no Bottle Feeding ( )no ( )yes -Breastmilk /Formula _____
Breastfeeding Problems:
( ) Latch Issues ( ) Milk Transfer Issues ( ) Excessive Air/Gas ( ) Lip Blister
( ) Staying on Breast ( ) Long BF Sessions ( ) Feeding Frequency ( ) Reflux
( ) Maternal Pain/Symptoms _____
Lactation Consultant_____
Has your child had any of the following conditions?

( ) Anemia ( ) Heart Condition
( ) Asthma or Lung Problems ( ) Failure to Gain Weight
( ) Kidney Disease ( ) HIV
( ) Bleeding Disorder ( ) Hearing Impairment
( ) Cerebral Palsy ( ) Jaundice
( ) Cleft Lip/ Cleft Palate ( ) Sickle Cell Anemia
( ) Delayed Development

Any problems not listed above ()No ()Yes:_____
Please list all medications your child is currently taken: ()None
_____
Is Your Child ALLERGIC or has your child had an ADVERSE REACTION to any medication?
( )No ()Yes: _____
Surgeries or Anesthesia History: ()none

Any history of life-threatening anesthesia complications in the family? ( )No ()Yes:
_____
Primary Physician/Pediatrician:_____
Other Physicians/Specialists:_____

I understand that the information that I have given is correct to the best of my knowledge and it is my responsibility to inform the office of any changes in my child's medical status.

I have had full opportunity to read the Consent form and Notice of Privacy Practices (HIPAA).

The parent or guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved. I have had full opportunity to read the Office Financial Policies.

Date: _____Parent/Guardian Name_____Signature_____