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: _____

Last Dental Exam: _____ by Dr._____ Last X-Rays:_____

Past Dental Treatment: _____

Medical History

Has your child had any of the following conditions?

( ) Anemia
( ) Asthma / Lung Problems
( ) Kidney Disease
( ) Bleeding Disorder / Hemophilia
( ) Cerebral Palsy
( ) Cleft Lip/ Cleft Palate
( ) Delayed Development
( ) Autistic Spectrum Disorder / Aspergers
( ) Pregnant
( ) Cancer
( ) Emotional Disturbance
( ) Heart Condition/ Murmur
( ) Failure to Thrive/ Low Weight
( ) Immunologic Disorder/ HIV
( ) Hearing Impairment
( ) Liver Disease / Jaundice
( ) Sickle Cell Anemia
( ) Premature Birth (____ weeks)
( ) Diabetes / Endocrine Disorder
( ) Intellectual Disability
( ) Seizures / Epilepsy

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:_____

Pharmacy: _____ Location/Phone:_____

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_____