Raymond Katz, DMD
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Dentistry for Children and Young Adults

(415) 751-7900

San Francisco Office
5233 Geary Boulevard
San Francisco, CA 94118

Marin Office
163 Miller Avenue #2
Mill Valley, CA 94941

PATIENT REGISTRATION

Child's Name _____ Nickname _____ Birthdate _____
First *Middle* *Last*

Sex ❑ M ❑ F School _____ Name of child's pet _____ Interests _____

Have we seen other children in your family? ❑ Y ❑ N If yes, names _____

Whom may we thank for referring you to our office? _____

Parent's/Guardian's Name _____
Social Security # _____ Birthdate _____
Home Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Employer _____ Work Phone _____
Email Address _____

Parent's/Guardian's Name _____
Social Security # _____ Birthdate _____
Home Address _____
City _____ State _____ Zip _____
Home Phone _____ Cell Phone _____
Employer _____ Work Phone _____
Email Address _____

Child lives with: ❑ Both Parents ❑ Mother ❑ Father ❑Other _____

Person/s financially responsible for account: ❑ Both Parents ❑ Mother ❑ Father ❑Other _____

FOR PATIENTS COVERED BY DENTAL INSURANCE

PRIMARY DENTAL INSURANCE

Insured Person's Name _____
Social Security # _____ Birthdate _____
Employed By _____
Insurance Company _____
Insurance Address _____
City _____ State _____ Zip _____
Group # _____

I hereby authorize payment directly to Raymond H. Katz, DMD of the insurance benefits otherwise payable to me.

_____
Signed (Insured Person) *Date*

SECONDARY DENTAL INSURANCE

Insured Person's Name _____
Social Security # _____ Birthdate _____
Employed By _____
Insurance Company _____
Insurance Address _____
City _____ State _____ Zip _____
Group # _____

I hereby authorize payment directly to Raymond H. Katz, DMD of the insurance benefits otherwise payable to me.

_____
Signed (Insured Person) *Date*

If you are unable to keep your appointment, we would appreciate 48 hours notice so that we may offer that time to other patients.
A charge of $50.00 will be assessed with every missed appointment or last minute cancellation.

GETTING TO KNOW YOUR CHILD

Welcome to our office! Please fill out this form as completely as possible. This information will be of great value in helping us make this dental visit a positive experience for your child.

Is this your child's first dental visit? ❑ Y ❑ N What is the reason for this visit? _____
If no, name of former dentist? _____ Date & purpose of last visit _____
What is your child's attitude toward previous dental care? _____
Does your child brush daily? ❑ Y ❑ N Does an adult assist with the brushing? ❑ Y ❑ N
Does your child floss daily? ❑ Y ❑ N Does an adult assist with the flossing? ❑ Y ❑ N
Does your child have any of the following *mouth habits*?

❑ Thumb sucking ❑ Nail biting ❑ Lip sucking
❑ Mouth breather ❑ Teeth grinding ❑ Pacifier ❑ Other _____

Does your child receive *fluoride* in any of the following forms?

❑ In toothpaste ❑ In water supply ❑ In rinse/gel ❑ In tablets: Dosage _____ mg/day

MEDICAL INFORMATION

Child's Pediatrician _____ Address _____ Phone # _____
Has your child received all immunizations? ❑ Y ❑ N
Is your child being treated for any condition presently? ❑ Y ❑ N If yes, please explain _____
Is your child taking any *medications* or drugs? ❑ Y ❑ N If yes, please list _____
Has your child ever been hospitalized? ❑ Y ❑ N If yes, for what reason? _____
Is your child *allergic* to any medications? ❑ Y ❑ N Please list & describe reaction _____
Does your child have any allergies to (please circle): pollen food dust animals other _____

Has your child ever been diagnosed as having any of the following conditions?

Y	N		Y	N		Y	N		Y	N	
❑	❑	Anemia	❑	❑	Cerebral Palsy	❑	❑	Fainting/Dizziness	❑	❑	Motion Sickness
❑	❑	Asthma	❑	❑	Child Abuse	❑	❑	Gag Reflex	❑	❑	Nosebleeds
❑	❑	Bladder Conditions	❑	❑	Cancer or Malignancies	❑	❑	Hearing Disorders	❑	❑	Rheumatic Fever
❑	❑	Bone Disorder	❑	❑	Developmental Problems	❑	❑	Heart Problems	❑	❑	Seizures
❑	❑	Brain Injury	❑	❑	Diabetes	❑	❑	Hepatitis	❑	❑	Speech Disorder
❑	❑	Bruising Easily	❑	❑	Earaches	❑	❑	Kidney Disease			

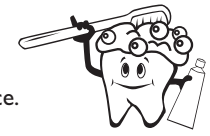
Comments/Details _____

Has your child ever had any *injuries* to his/her teeth, mouth, or head?
If so, please describe _____

Does your child have any phobias? _____ Any emotional or school problems? _____
How would you describe you child's learning? slow _____ average _____ accelerated _____
Please check any of the following that may describe your child:

❑ Outgoing ❑ Shy ❑ Stubborn ❑ Anxious ❑ Frightened ❑ Regular kid

How may we help to make this visit a positive experience for your child? _____



Regardless of any insurance coverage, I agree to be responsible for payment of services performed for my child in this office.

Signature _____ Date _____
(Parent/Legal Guardian) *Relationship*