Dr. Ritu Bhardwaj, DDS
620 E. Alvin Dr. #E
Salinas, CA 93906
(831) 449-8363

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Tell Us About Your Child

Child's Name: ______________________________ Last First MI
Child's Birthdate: ___________________ Child's Age: ___________________
Nickname: __________________________ ☐ Male ☐ Female
School: ______________________________ Grade: ____________
Child's Home #: _______________________ SS #: _____________________
Child's Home Address: ____
________________________________ City State Zip
Email Address: ____

Who Is Accompanying The Child Today?

Name: __________________________ Relation: _______________________
Do you have legal custody of this child? ☐ Yes ☐ No
Is child adopted? ☐ Yes ☐ No Is child in a foster home? ☐ Yes ☐ No
Whom may we thank for referring you? _____________________________________
Other siblings seen by us: ____
Previous / Present Dentist: ____
Last Visit Date: ____
Parent's Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Partnered ☐ Separated

Parent's Information

☐ Mother ☐ Step Mother ☐ Guardian
Name: __________________________________ Birthdate: ______________
Email Address: ____
Cell #: _______________________ Hm #: _________________________
Employer: __________________________ Wk #: _____________________
SS #: __________________________ DL #: _______________________
☐ Father ☐ Step Father ☐ Guardian
Name: __________________________________ Birthdate: ______________
Email Address: ____
Cell #: _______________________ Hm #: _________________________
Employer: __________________________ Wk #: _____________________
SS #: __________________________ DL #: _______________________

Person Responsible for Account

Name: _______________________________ Relation: _____________________
Billing Address: ____
________________________________ City State Zip
Wk #: ___________________ Ext: ______ Hm #: _____________________
Employer: ____
DL #: __________________________ SS #: __________________________
Who is responsible for making appointments?
Name: ____
Wk #: ___________________ Ext: ______ Hm #: _____________________

Primary Dental Insurance

Insurance Co. Name: ____
Insurance Co. Address: ____
Insurance Co. Phone #: ____
Group # (Plan, Local, or Policy #): _______________________________________
Policy Owner's Name: ____
Relationship to Patient: ____
Policy Owner's Birthdate: ________________ ID #: _______________________
Policy Owner's Employer: ____
Employer's Address: ____
Orthodontic Coverage? ☐ Yes ☐ No

Secondary Dental Insurance

Insurance Co. Name: ____
Insurance Co. Address: ____
Insurance Co. Phone #: ____
Group # (Plan, Local, or Policy #): _______________________________________
Policy Owner's Name: ____
Relationship to Patient: ____
Policy Owner's Birthdate: ________________ ID #: _______________________
Policy Owner's Employer: ____
Employer's Address: ____
Orthodontic Coverage? ☐ Yes ☐ No

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Why did you bring the child to the dentist today?

Has the child ever had a serious / difficult problem associated with previous dental work? □ Yes □ No
Is the child's water fluoridated? □ Yes □ No
Is the child taking fluoridated supplements? □ Yes □ No
Has the child ever had any pain / tenderness in his/her jaw joint (TMJ / TMD)? □ Yes □ No
Does the child brush his / her teeth daily? □ Yes □ No
Floss his / her teeth daily? □ Yes □ No
Child's Physician: ____________________
Phone #: ____________________ Date of Last Visit: ____________________
Is the child currently under the care of a physician? □ Yes □ No
Please describe the child's current physical health: □ Good □ Fair □ Poor
Has the child ever taken Fosamax, Actonel, Boniva or any other bisphosphonate? □ Yes □ No

Please list all drugs that the child is currently taking:

Aside from items listed below, list all drugs/things the child is allergic to:

Latex □ Yes □ No Metals/Nickel □ Yes □ No Plastic □ Yes □ No

Has the child ever had any of the following medical problems?

Y N Abnormal Bleeding	Y N Handicaps / Disabilities
Y N ADD / ADHD	Y N Hearing Impairment
Y N Anemia	Y N Heart Murmur
Y N Any Hospital Stays	Y N Hemophilia
Y N Any Operations	Y N Hepatitis
Y N Artificial Bones/Joints/Valves	Y N Hives
Y N Asthma	Y N HIV+ / AIDS
Y N Cancer	Y N Kidney / Liver Problems
Y N Chicken Pox	Y N Measles
Y N Congenital Heart Defect	Y N Mononucleosis
Y N Convulsions	Y N Rheumatic / Scarlet Fever
Y N Diabetes	Y N Sickle Cell Disease / Traits
Y N Epilepsy	Y N Skin Rash
Y N Exposed to HIV, but Neg.	Y N Tuberculosis (TB)

Are the Child's Immunizations current? □ Yes □ No
Anything you would like to discuss with the Doctor in private? □ Yes □ No
Please discuss any serious medical problems that the child has had:

Does/did the child experience any of the following?
Y N Lip Sucking / Biting Y N Nursing Bottle Habits
Y N Nail Biting Y N Thumb / Finger Sucking
Was the child breast fed? □ Yes □ No

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.
I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.
My method of payment will be: ______________________________

Signature of parent or guardian Date

I certify that my child is covered by ________________ Insurance Co. and I assign directly to Dr. ________________ all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of parent or guardian Date