Sumalee Sangsurasak, DDS Inc   Pediatric Dentistry 1121 E. Green St. Pasadena, Ca. 91106 626-792-2782

Patient Information

FIRST Name: ______________________LAST Name: ______________________ MI: __________

Date of birth: _________________________(month/ day/year)   School:________________________
Grade: ________

Home
Address:____

Reason for Visit:
____

Referred to this office by (we wish to thank them) :
____

History

Patient's Physician name: ____
Phone : _____________________________

Address: ____
Last visit:_____________________________

Dental History

Patient's first dental visit:
____

Previous dentist: _________________________City: ___________________________Last visit:_____________________

History of Thumb sucking/ Finger sucking/ Nail biting/ Lip sucking/ Pacifier Usage:

____

How do you think your child will act toward the dentist?
____

How often does your child brush? Using toothpaste?
____

Parent / Legal Guardian/ AUTHORIZATION FAMILY INFORMATION AND FINANCIAL RESPONSIBILITY

Parent's full name: First: _________________ Last :_______________________ MI: ________

Employed by:________________________ Occupation: ______________Cell #: ________________

Business address: _______________________________ Business phone #: __________________

Date of Birth: ___________Social Security #:(for insurance filing) _________________________

Parent's (spouse) full name: First: ________________Last:________________________MI: _____

Employed by: _____________________ Occupation: _________________Cell #: ________________

Business address: ____
Business phone #: __________________

Date of Birth: _______________________
Social Security #:(for insurance filing) ____________________________

Child's Primary dental
Insurance:____

Name of Policy
Holder:____

ID number of Policy Holder and Group
number:____

Child's Secondary dental
Insurance:____

Name of Policy
Holder:____

ID number of Policy Holder and Group
number:____

Names of The child's brothers and sisters :
____

Has any member of your family been a patient in this office before?:
____

Email: __________________________ **Text number:** _________________________________

I hereby authorize Dr. Sangsurasak, and/or her associates to provide dental treatment for my above named child. I consent to such treatment, medications and treatment methods as Dr. Sangsurasak, her associates and staff deem appropriate in providing the safest and best possible dental care for my child. I understand that prior to any treatment being rendered, a full explaination of the diagnosis, procedures, alternative treatment and consequences if no treatment is done. I agree to assume full financial responsibility for my child's dental care and treatment with Sumalee Sangsurasak, DDS, Inc. I understand that there is a charge for broken appointment unless the office is notified 48 hours in advance.

If the family is not living together, the parent accompanying the child is responsible for the account.

I understand and acknowledge my rights as detailed in the Notice of Privacy Practices Presented here.

Signature: ________________________________ **Date:** __________________________

Name: ________________________ **Relationship to child:** _____________________________