Dr. Surillo's
CENTER FOR
PEDIATRIC DENTISTRY AND ORTHODONTICS
DUAL SPECIALIST SINCE 1995
Santiago A. Surillo • DDS, MS, Diplomate of the American Board of Orthodontics
619-461-6166 • www.sandiegokidsdentist.com

ABOUT YOUR CHILD

_____
CHILD'S FULL NAME

_____
NAME CHILD PREFERS TO BE CALLED

_____ ☐M ☐F _____
AGE DATE OF BIRTH

_____
WEIGHT HEIGHT

_____
REASON FOR VISIT

REFERRED BY _____
FULL NAME

_____
PHONE #

DENTAL HISTORY

CHILD'S FIRST DENTAL VISIT ☐ YES ☐ NO

_____
PREVIOUS DENTIST CITY

DATE OF LAST VISIT _____

ANY INJURIES TO YOUR CHILD'S TEETH, JAWS, HEAD OR NECK? ☐ YES ☐ NO
WHEN? _____

HISTORY OF: WHEN?
☐ Nursing bottle habits _____
☐ Thumb/finger/lip habits _____
☐ Pacifier _____
☐ Recent dental pain _____
☐ Previous dental treatment _____

HAS YOUR CHILD EXPERIENCED ANY UNFAVORABLE REACTION FROM PREVIOUS MEDICAL OR DENTAL CARE?
☐ YES ☐ NO (Please explain)
_____
_____

PLEASE RELATE ANY INFORMATION THAT WILL HELP US UNDERSTAND YOUR CHILD
_____
_____
_____

MEDICAL HISTORY

_____
CHILD'S PHYSICIAN/PEDIATRICIAN PHONE #

- Does your child have a history of health problems or any illnesses? ☐ Yes ☐ No
  Please explain: _____
  _____
- Is your child presently under the care of his/her physician for any medical reason? ☐ Yes ☐ No
  Please explain: _____
  _____
- Is your child presently under the care of a specialist for any medical reason? ☐ Yes ☐ No
  Please explain: _____
  _____

_____
SPECIALIST'S NAME PHONE #

- Are antibiotics necessary for dental treatment because of heart murmur, heart defect, prosthesis, shunt or other medical reason? ☐ Yes ☐ No
- Is your child presently taking any medications? ☐ Yes ☐ No
  What? _____
- Has your child had a history of taking medications frequently? Which ones? _____ ☐ Yes ☐ No
- Has your child ever been hospitalized or had surgery Including same-day surgery? ☐ Yes ☐ No
  For what _____
- Is your child allergic to any drugs/medicines? ☐ Yes ☐ No
- Has your child ever had any adverse reactions to any medications, drugs, or latex? ☐ Yes ☐ No
  If yes, what? _____
- Has your child or any member of his/her family ever had a problem with a general anesthetic? ☐ Yes ☐ No
  Please explain: _____

HAS YOUR CHILD EVER BEEN DIAGNOSED AS HAVING ANY OF THE FOLLOWING CONDITIONS? CHECK YES OR NO:

Y	N		Y	N	
☐	☐	AIDS/HIV	☐	☐	Fever Blisters
☐	☐	Anemia	☐	☐	Growth /Development Problems
☐	☐	Arthritis			
☐	☐	Asthma	☐	☐	Heart Surgery
☐	☐	Autism	☐	☐	Headaches
☐	☐	Bladder Conditions	☐	☐	Hearing/Speech Impediment
☐	☐	Blood Disease			
☐	☐	Birth Defects	☐	☐	Heart Murmur/Defect
☐	☐	Bone or Joint Problems	☐	☐	Hemophilia
☐	☐	Brain Injury	☐	☐	Hepatitis/Liver Disease
☐	☐	Bruising Easily	☐	☐	Hyperactivity/ADD
☐	☐	Cancer or Malignancies	☐	☐	Kidney Disease
☐	☐	Cerebral Palsy	☐	☐	Leukemia
☐	☐	Chemotherapy/Radiation	☐	☐	Mental Disability
☐	☐	Child Abuse	☐	☐	Mouth Sores
☐	☐	Chronic Adenoid/ Tonsil Infection	☐	☐	Nutritional Deficiency
			☐	☐	Orthopedic Problems
☐	☐	Chronic Ear Infections	☐	☐	Pain in Jaw Joints
☐	☐	Cleft Lip/Palate	☐	☐	Premature Birth
☐	☐	Congenital Heart Defects	☐	☐	Psychiatric Care
☐	☐	Convulsions/Seizures	☐	☐	Rheumatic Fever
☐	☐	Developmental Delay	☐	☐	Scoliosis
☐	☐	Diabetes	☐	☐	Sickle Cell Anemia
☐	☐	Drug Addictions	☐	☐	Snoring/Mouth Breathing
☐	☐	Emotional Disturbance	☐	☐	Syndrome _____
☐	☐	Epilepsy	☐	☐	Tuberculosis
☐	☐	Eye Problems	☐	☐	Other_____
☐	☐	Excessive Bleeding	☐	☐	Do you wish to talk to the doctor privately about a special concern?
☐	☐	Excessive Gagging			
☐	☐	Fainting or Dizziness			

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I understand that I am financially responsible for all charges, whether or not covered by my insurance company. I permit payment directly to Dr. Santiago Surillo. Authorization is hereby granted for release of information required to process any claims. A copy of this authorization is valid as the original. Regardless of any claim pending, I will receive periodic statements if my account balance has any outstanding balance.
I understand that Dr. Santiago Surillo is not responsible for collecting on my insurance claims and/or negotiating a settlement on a disputed claim. Furthermore, I accept financial responsibility for my account.

PATIENT/RESPONSIBLE PARTY SIGNATURE _____ DATE

INSURANCE INFORMATION

INSURED'S NAME _____ DOB

ADDRESS/PHONE (IF DIFFERENT) _____

PRIMARY INSURANCE _____ ADDRESS

GROUP # _____ POLICY #

DUAL COVERAGE? ☐YES ☐ NO

SECONDARY INSURANCE _____ ADDRESS

GROUP # _____ POLICY #

RESPONSIBLE PARTY FATHER/MOTHER

FATHER'S FULL NAME (OR LEGAL GUARDIAN) _____

ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

SOCIAL SECURITY # _____ BIRTH DATE _____ E-MAIL _____

HOME PHONE # _____ BUSINESS PHONE # _____ CELL # _____

OCCUPATION _____ EMPLOYER _____ E-MAIL _____

MOTHER'S FULL NAME (OR LEGAL GUARDIAN) _____

ADDRESS (IF DIFFERENT) _____

CITY _____ STATE _____ ZIP CODE _____

SOCIAL SECURITY # _____ BIRTH DATE _____

HOME PHONE # _____ BUSINESS PHONE # _____ CELL # _____

OCCUPATION _____ EMPLOYER _____

PARENTS ARE:
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Legal Guardian

THE PERMISSION OF THE PARENT OR LEGAL GUARDIAN IS NECESSARY FOR DENTAL TREATMENT OF A MINOR.

I give doctor Surillo permission to use such measures as deemed necessary in their professional judgement to render a diagnosis for my child. This would include an oral examination, radiographs (X-rays) and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have also reported any prior allergic and/or unusual reactions to drugs, food, anesthetics, blood or body diseases, gum or skin reactions, abnormal bleeding or any other conditions related to my child's health or any other physical conditions that my child's medical doctor has advised me.

- I hereby certify the foregoing information is true and correct. _____ SIGNATURE _____ DATE
- I authorize release of any information relating to this claim. I understand that I am responsible for all costs of dental treatment. _____ RELATIONSHIP _____ SIGNED (PATIENT OR PARENT OF MINOR)
- I hereby authorize payment to the above named dentist of the group insurance benefits otherwise payable to me. _____ SIGNED (INSURED PERSON)