William Y. Gregg, D.D.S., F.A.G.D., Inc
Daniel B. Balaze, D.M.D., F.A.G.D.

Personalized Denistry

FAX: 949/770-0725

30131 Town Center Dr. #250 ● Laguna Niguel, CA 92677

949/770-7686

Date ____________

CHILD INFORMATION

Child's Name ______________________________ Birthdate ____________________

Nickname ____________ Who may we thank for referring you to us? ____________________

Home Phone ____________________ Cell Phone to contact parent ___ ____________________

Address ____
Street City Zip

Previous address if less than 1 year? ______________________________
Street City Zip

Father ____________________ **Mother** ____________________

Occupation ____________________ Occupation ____________________

Employer ____________________ Employer ____________________

Address ____________________ Address ____________________

____________________ ____________________

Work Phone ____________________ Work Phone ____________________

Who is financially responsible for this account? ____________________ Relationship to child? ____________

Signature ____________________ Drivers License # ____________________

Address ______________________________ Phone ____________
Street City Zip

Dental Insurance

Primary Insurance

Insured Name ____________________ Soc. Sec # ____________ Birthdate ________

Insurance Company ____________________ Group # ____________ Plan # ______

Address ______________________________ Phone ____________
Street City Zip

Employer Name ______________________________ Phone ____________

Effective Date ____________ Deductible ____________ Annual Limits ____________

Limitations or Restrictions? ____________________________________

Secondary Insurance

Insured Name ____________________ Soc. Sec # ____________ Birthdate ________

Insurance Company ____________________ Group # ____________ Plan # ______

Address ______________________________ Phone ____________
Street City Zip

Employer Name ______________________________ Phone ____________

Effective Date ____________ Deductible ____________ Annual Limits ____________

Limitations or Restrictions? ____________________________________

Medical History

Physician ______________________________ Phone ______________

Physician ______________________________ Phone ______________

Is the child currently under the care of a physician? ________ Reason: ______________

Is the child in good health? __________ Have there been any serious illnesses, hospitalizations or surgeries? __________

Please Describe: ______________________________

Does the child have or ever had: | **Date of last Physical Exam** ______________

yes	*no*		*yes*	*no*	
☐	☐	A current medical problem?	☐	☐	Circulatory Problems?
☐	☐	Any heart problems?	☐	☐	Rheumatic Fever?
☐	☐	A heart murmur?	☐	☐	Prolapsed Mitral Valve?
☐	☐	Congenital Heart Disease?	☐	☐	Diabetes?
☐	☐	Hypoglycemia?	☐	☐	Excessive Bleeding?
☐	☐	Blood Disease?	☐	☐	Blood Transfusion?
☐	☐	Adenoids out?	☐	☐	Tonsils out?
☐	☐	Sinus infections?	☐	☐	AIDS or Positive HIV Test?
☐	☐	Respiratory(Breathing) Problems?	☐	☐	Hay Fever?
☐	☐	Asthma?	☐	☐	Hepatitis?
☐	☐	Kidney Disease/Dysfunction?	☐	☐	Liver Disease/Dysfunction?

Have you been advised to have the child take antibiotics before dental treatment? ______________

Are there any allergies or unusual reactions to any medications?

- ☐ Penicillin ☐ Erythromycin ☐ Sulfas
- ☐ Ceclor ☐ Aspirin ☐ Acetaminophen("Tylenol")
- ☐ Local Anesthetics ("Novocain" or "Lidocaine")
- ☐ Others ______________________________

Please list any medications the child is now taking:

Medication	Dose	Reason

Does you child receive fluoride in vitamins, tablets or water? ______________

Dental History

What is your immediate concern? ______________________________

Previous Dentist ______________________________ Phone ______________

Address ______________________________
Street City Zip

Date of last dental visit: ______________ Reason ______________

Is this your child's first dental visit? __________ Is the child worried/apprehensive? __________ Are you? __________

Has the child had an unfavorable experience in a previous dental or medical office? ________ Please Describe ______________

Do you feel any apprehension about "the dentist" has been passed on to the child by you? __________ By Others? ________

Have regular preventive dental visits been made? ________ How often? ______________

Has the child had a cavity? __________ Do either parent have a history of dental decay? ______________

Are you aware of : Thumbsucking? ☐ Tongue Thrust? ☐ Mouth Breathing? ☐ Grinding? ☐

Do you feel you understand how to prevent dental problems for your child? ______________

To the best of my knowledge, all of the preceding answers are true and correct. If there is a change in the health or medications for this child, I will inform the doctor. I understand that, unless arrangements are made in advance, the person who brings the child in for treatment is financially responsible.

Permission is hereby granted to the doctor to perform any necessary dental treatment for this child.

Signature ______________________________ Relationship ______________ Date ______________

Daniel B. Balaze, DMD, FAGD
William Y. Gregg, DDS, FAGD

Things are changing. To do our best to keep up to date, we want to inform you of our attempts to go the extra mile for you.

CONSENT

I authorize Dr. Gregg, Dr. Balaze and staff to take X-rays, impressions, photographs or other diagnostic aids deemed appropriate to make a thorough diagnosis of any dental and oral conditions. I understand that any dental treatment involves some form of risk. I understand records including photographs may be used for educational purposes and may be published or displayed in seminars and marketing.

*Signature*________________________ Date ____________________ Staff ________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We may send unencrypted digital communications for patient care communication.

****You May Refuse to Sign This Acknowledgement****

I have received a copy of William Y Gregg, DDS, Inc. office's Notice of Privacy Practices.

____
{Please Print Name}

____
{Signature}

____
{Date}

____
{Personal Representative on behalf of Patient name above}

____
{Relationship to Patient}

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

0 Individual refused to sign

0 Communication barriers prohibited obtaining Acknowledgement

0 An emergency situation prevented us from obtaining Acknowledgement

0 Other(PleaseSpecify)

____

ACKNOWLEDGEMENT OF REVIEW OF DENTAL MATERIALS FACT SHEET DATED 5/2004

I,________________________, acknowledge a copy of the Dental Materials Fact Sheet has been made available to me including a copy if requested.

____
{Patient Name}

____
{Signature}

____
{Date}

____
{Personal Representative on behalf of Patient name above}

____
{Relationship to Patient}

____
{Signature

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William Y. Gregg, DDS, FAGD, Inc
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Laguna Niguel, CA 92677
(949) 770-7686

PHOTO RELEASE FORM

I, ________________________________, hereby grant permission to Drs. Balaze and Gregg, to use my photographs in teaching materials used to provide dental continuing education. I acknowledge Drs. Balaze and Gregg right to crop or otherwise treat the photograph at his/her discretion. I also acknowledge that the doctor may choose not to use my photographs at this time, but may do so at their own discretion at a later date. I also understand that once my image is posted on a web site, any computer user, which is beyond the control of Drs. Balaze and Gregg, can download the image and I will hold him/her and any of his affiliated offices harmless from any such use or download.

I hereby freely and voluntarily consent to the use of my photograph and testimonial as stated above until I revoke this consent in writing.

______________________ Signature	______________________ Parent/Guardian Signature (If under age of 18)
______________________ Printed Name	______________________ Parent/Guardian Printed Name (If under age of 18)
______________________ ______________________ Address	______________________ ______________________ Parent/Guardian Address (If under age of 18)
______________________ Date	______________________ Date

To revoke this consent in writing, please contact:

Daniel Balaze, DMD, FAGD
William Gregg, DDS, FAGD
30131 Town Center Drive, Suite 250
Laguna Niguel, CA 92677