Child's Name _____ Nickname _____

Sex: M ☐ F ☐ Birth Date _____ Age _____ Reason for this visit? _____

Is this your child's first dental visit? ___ Date of last visit _____ Previous Dentist_____

Your child's attitude toward previous dental care? _____

Names of siblings: Name _____ Age _____ Name _____ Age _____

Name _____ Age _____ Name _____ Age _____

Is your child adopted? _____ Who has legal guardianship of your child? _____

How did you hear about our office? _____

MEDICAL INFORMATION

Dr.'s Name _____ Address _____ Phone _____

Is your child taking any medication? ___ What kind? _____

Reason _____

Has your child ever been hospitalized? ___ When? _____ Reason _____

Has your child had a history or difficulty with any of the following:

YES	NO		YES	NO		YES	NO	
☐	☐	Seasonal Allergies	☐	☐	Asthma/Breathing Problems	☐	☐	Arthritis
☐	☐	Autism	☐	☐	Anemia/Bleeding	☐	☐	Bones
☐	☐	Cancer/Tumors	☐	☐	Cerebral Palsy	☐	☐	Cleft Lip/Palate
☐	☐	Developmental	☐	☐	Diabetes	☐	☐	Eyes, Ears, Nose, Throat
☐	☐	Hearing	☐	☐	Heart	☐	☐	Kidney/Liver
☐	☐	Hepatitis	☐	☐	Immune Deficiency	☐	☐	Liver
☐	☐	General Anesthesia/Surgery	☐	☐	Seizures/Epilepsy/Convulsions	☐	☐	Stomach/Intestinal
☐	☐	Syndromes	☐	☐	Other _____			

Comments / Details _____

Does your child have any emotional or school problems? _____

Allergies to Food or Medications _____

DENTAL INFORMATION

Was your child bottle fed? _____ Until what age? _____ Or breast fed? _____ Until what age? _____

Does your child have any mouth habits, such as : finger/thumb sucking _____ pacifier _____ other _____

Has your child ever had any injuries to his teeth, mouth or head? _____ When? _____ Details _____

Does your child brush regularly? _____ Does an adult assist with brushing? _____

Does your child floss? _____ Does an adult assist in flossing? _____

Has either parent or child been treated orthodontically? _____ Name of Orthodontist? _____

How would you expect your child to behave in our office? _____

Describe your child: Outgoing ☐ Shy ☐ Stubborn ☐ Anxious ☐ Frightened ☐ Age Appropriate ☐

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

RESPONSIBLE PARTY

First Name _____ Last Name _____ Middle Initial ____

Address _____ City, State, Zip _____

Home Phone _____ Work Phone _____ Cell _____

Birth Date _____ Soc Sec _____ Maasn_rgol _____

Ck_gj _____ &uc bm kmqr msp amk k s l ga_rgml tg_ ck_gj* and NEVER qn_k'

U fm a_l uc rf_l i dmp pcdcppg l e wms rm msp np_argac= _____

MOTHER'S INFORMATION (if different from responsible party)

Name _____ Employer _____Occupation _____

Address _____ Cell #_____ Home #_____

FATHER'S INFORMATION (if different from responsible party)

Name _____ Employer _____Occupation _____

Address _____ Cell #_____ Home #_____

PRIMARY DENTAL INSURANCE

Policy Holder Name _____

Social Security# _____

Ins. Company Name_____

Policy/ Group Number _____

Ins. Address_____

Ins. Phone # _____

SECONDARY DENTAL INSURANCE (if any)

Policy Holder Name _____

Social Security# _____

Ins. Company Name_____

Policy/ Group Number _____

Ins. Address_____

Ins. Phone # _____

FINANCIAL POLICY

Your child's estimated share of cost is due and payable on the day the treatment is performed. Unless prior approved financial arrangements have been made. Understand that dental insurance may cover only part of your child's dental treatment, based on your specific dental benefit plan. We will do our best to provide you with an estimate based on your plan. Please understand that the contract for dental insurance is between you and your insurance company and not our practice. Any disputes of coverage need to be handled through the insurance company directly by you and you accept personal financial responsibility for services provided.

To avoid missed appointment charges we request that you infomr us of cancelation notice 48 hours prior to the appointment, so that we can offer the appointment to another child. If you have 2 broken appointments, you will be automatically charged $50.00 for your missed appointments. A broken appointment is considered a "no show" or cancelling an appointment the same day.

The signature of the responsible party and/or Legal Guardian below authorizes Dr. J Shahangian or qualified assignee to complete the following agreed upon necessary dental services. Comprehensive Examination, Cleaning, Fluoride and Diagnostic X-rays.

SIGNATURE _____ **RELATIONSHIP TO CHILD** _____ **DATE** _____