Healthy Teeth & Gums Start Here

J. Shahangian, DDS, MS

(858)MY-FLOSS(693-5677)



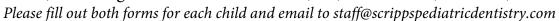
 ${\it Please complete both pages for each child and email to staff@scrippspediatricdentistry.com}$

Child's Name	Nickname				
Sex: M F Birth Date	Ag	e Reasc	on for this visit?		
Is this your child's first denta	l visit? Date o	f last visit	Previous	Dentist	
Your child's attitude toward 1	previous dental car	e?			
Names of siblings: Name		Age	Name		Age
Name		Age	Name		Age
Is your child adopted?	Who has legal gu	ardianship of vo	our child?		
How did you hear about our	0 0				
,					
MEDICAL INFORMAT	ION				
Pr.'s Name Address		3		_ Phone _	
Is your child taking any medi	cation? What	kind?			
Reason					
Has your child ever been hos	-				
Has your child had a history	or difficulty with a	ny of the followi	ing:		
Seasonal Allergi Autism Cancer/Tumors Developmental Hearing Hepatitis General Anesthesia/S		Anemia/Blee Cerebral Pals Diabetes Heart Immune Def Seizures/Epile	sy		Arthritis Bones Cleft Lip/Palate Eyes, Ears, Nose, Throat Kidney/Liver Liver Stomach/Intestinal
Comments / Details					
Does your child have any em	otional or school p	roblems?			
Allergies to Food or Medicat	ions				
DENTAL INFORMATI Was your child bottle fed?	Until what ag				
Does your child have any mo		•			
Has your child ever had any i	•				ils
Does your child brush regula				_	
Does your child floss?					
Has either parent or child bee		-			
How would you expect your					
Describe your child: Outgoin			nxious Frighte	ened .	Age Appropriate
How may we help to make th	is visit a positive e	xperience for vo	ur child?		

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RESPONSIBLE PARTY

First Name	Last Name	Middle Initial		
Address	City, State, Zip			
Home Phone	Work Phone	Cell		
Birth Date	Soc Sec En	Employer		
Email	(we do most of our comm	unications via email and NEVER spam.)		
Who can we thank for referring	you to our practice?			
MOTHER'S INFORMATION	ON (if different from responsible party)			
		Occupation		
		Date of Birth		
	N (if different from responsible party)			
	_ ,	Occupation		
Address	Cell #	Date of Birth		
PRIMARY DENTAL INSU	RANCE SECONDAR	RY DENTAL INSURANCE (if any)		
Policy Holder Name	Policy Holder Name			
Social Security#	Social Security	Social Security#		
Ins. Company Name	Ins. Company	Ins. Company Name		
Policy/ Group Number	Policy/ Group	Policy/ Group Number		
Ins. Address	Ins. Address_	Ins. Address		
Ins. Phone #	Ins. Phone # _			
covers only part of the fees for service estimate accordingly. Please understand our practice. Any disputes of coverage financial responsibility for services provided appointment charges we can offer the appointment to anoth missed appointments. A broken appointment of the responsible party of the signature of the signature of the responsible party of the signature of the responsible party of the signature of the	es based on your specific dental benefit under de that the contract for dental insurance is bet need to be handled through the insurance covided. Your signature here authorizes assignment we request that you inform us of cancelation are child. If you have 2 broken appointments, you nament is considered a "no show" or cancelling. Legal Guardian below authorizes Dr. J Shahar	notice 48 hours prior to the appointment, so that you will be automatically charged \$50.00 for your g an appointment the same day.		
·		stic X-rays as indicated to evaluate oral health.		
SIGNATURE	RELATIONSHIP TO CHILD	DATE		