Maryam Sina, D.D.S.

Dentistry For Children

Welcome. We offer you friendship & extraordinary pediatric dental care.

Please fill in your answers as thoroughly as possible. This will help in developing a complete dental health program for your child. Of course, all information will be held in strict confidence

Date _____

Patient's Name _____ **Nickname** _____
First Middle Last

Date of Birth___/___/____ Sex: ☼Female ☼Male

Home Street Address_____

City_____ Zip_____

Home Telephone (___)_____

School _____Grade_____

Who is accompanying this child today? Name: _____Relation:_____

Do you have legal custody of this child? Yes ☐ No ☐

Mother's name:_____

☼Step Mother ☼Guardian ☼Married, ☼Divorced, ☼Single

Date Of Birth: ____/____/__

Employer:_____ Occupation:_____

Home #: (____)_____ Work #: (____)_____Ext:_____

Social Security #: _____ DL #: _____

Cell Phone _____E-Mail Address: _____

Please circle above mode of communication you prefer and appointment reminders.

Father's Name: _____

☼Step Father ☼Guardian ☼Married, ☼Divorced, ☼Single

Date Of Birth: ____/____/____

Employer:_____ Occupation:_____

Home #:(____)_____Work #: ( )_____Ext:_____

Social Security #: _____ DL #: _____

Cell Phone _____E-Mail Address: _____

Please circle above mode of communication you prefer.

Other family members seen by us?_____

Previous/Present Dentist: _____Last Visit Date: _____

Whom may we thank for referring you ?_____

- **PRIMARY DENTAL INSURANCE:**

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (___)_____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to patient:_____

Policy Owner's Date of Birth: _____/_____/_____ SS #: _____

Policy Owner's Employer: _____

- Federal law requires that the parent or guardian who brings the child to the appointments is responsible for the incurred fees.
- I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance on my account for any professional services rendered.
- I certify this information is true and correct to the best of my knowledge.
- I will notify you of any changes in my child's health status or the above information.
- I understand that Dentistry For Children files insurance claims electronically. This is acceptable to me.

_____ Date _____

Signature relationship to patient

DENTAL HEALTH:

Why did you bring your child to the dentist today? _____

How long has it been since your child's last exam? _____last cleaning?_____

For most drinking & cooking do you use: ☼town water ☼well-water ☼bottled water

If well or bottled, has water been tested fluoride? …… ☼Yes ☼No

Results? _____

Does your child take fluoride supplements? …… ☼Yes ☼No

Dose_____Frequency_____

Have there been any injuries to the face, mouth or teeth?… ☼Yes ☼No

Please give dates and descriptions_____

Has your child ever sucked a thumb or fingers?…… ☼Yes ☼No

- Pacifier?…… ☼Yes ☼No

Any other habits? _____For thumb, pacifier until what age? _____

Does your child have:

Snoring…… ☼Yes ☼No

Daytime mouthbreathing…… ☼Yes ☼No

Nighttime mouthbreathing…… ☼Yes ☼No

Tooth grinding…… ☼Yes ☼No

Bedwetting now…… ☼Yes ☼No

Hearing deficiency…… ☼Yes ☼No

Frequent middle ear infections…… ☼Yes ☼No

Environmental allergies…… ☼Yes ☼No

Taking medications? _____

History of sleep apnea…… ☼Yes ☼No

Restless Sleep…… ☼Yes ☼No

Speech problems…… ☼Yes ☼No

Have you been informed of any missing or extra permanent teeth? …… ☼Yes ☼No

Are there any unusual sounds in ear (clicking) during eating? …… ☼Yes ☼No

Has your child ever had an orthodontic examination or orthodontic treatment? ☼Yes ☼No

Does your child use a sippy cup?…… ☼Yes ☼No

Did your child go to sleep with a bottle, with a sippy cup, or while nursing? ☼Yes ☼No

Until what age? _____

- Is your child nervous or frightened during dental visits? If yes, please circle

  Least Nervous 0 1 2 3 4 5 6 7 8 9 10 Most Nervous

- It would be helpful if you would indicate below what things you are looking for most in choosing a pediatric dentist.

  _____

- Has your child had any unfavorable medical or dental experience?……☼Yes ☼No

If so, please explain_____

MEDICAL HEALTH:

- Is your child in good health?…… …. ☼Yes ☼No
- Date of last physical examination:_____
- Is your child now under the care of a physician?…… ☼Yes ☼No
  If so, what condition being treated?_____
- Did your child have trouble at birth or during the early years?……☼Yes ☼No
  Please describe_____
- Name of Pediatrician or Family Physician_____
  Address & Phone_____
- Has your child had any serious illness or injury?…… ☼Yes ☼No
  If so, what was the illness or injury?_____ Date_____
- Has your child received any blood transfusion?…… ☼Yes ☼No
  In what years?_____
- Has your child ever been hospitalized or had surgery?…… ☼Yes ☼No
  Date_____ Reason: _____
  Date_____ Reason: _____
- Has your child's tonsils or adenoids been removed?…… ☼Yes ☼No
  If yes, when _____

Does your child have or had your child had any of the following?

Rheumatic fever or rheumatic		Tuberculosis	☼Yes ☼No
Heart disease	☼Yes ☼No	Monoucleosis	☼Yes ☼No
Heart murmur	☼Yes ☼No	Low blood pressure	☼Yes ☼No
Congenital heart lesions	☼Yes ☼No	Thyroid problem	☼Yes ☼No
Physician has recommended antibiotics		Anemia	☼Yes ☼No
before dental procedures	☼Yes ☼No	Growth problems	☼Yes ☼No
Other Cardiovascular Disease	☼Yes ☼No	Stomach ulcers	☼Yes ☼No
Environmental allergies	☼Yes ☼No	Kidney problems	☼Yes ☼No
Hay fever or sinus problems	☼Yes ☼No	Birth defect (please describe):	
Asthma or breathing problems	☼Yes ☼No		
Hives or skin rash	☼Yes ☼No	Hearing problems	☼Yes ☼No
Fainting spells or seizures	☼Yes ☼No	Learning problems	☼Yes ☼No

Diabetes	☼Yes ☼No	Behavior problems	☼Yes ☼No
Hepatitis, jaundice or liver problems		Mental problems	☼Yes ☼No
……	☼Yes ☼No	Blood transfusion	☼Yes ☼No
(if jaundice, when newborn?)	☼Yes ☼No	HIV (AIDS)	☼Yes ☼No
Arthritis	☼Yes ☼No	Other	☼Yes ☼No
Limits on physical activities	☼Yes ☼No	_____	

- Has your child had abnormal bleeding with previous extractions, surgery, or trauma? …… ☼Yes ☼No
- Has your child been tested for sickle cell anemia?…….. ☼Yes ☼No
  If yes, what was the result?
  _____
- Does your child take any drug or medicine?…….. ☼Yes ☼No
  If so, what/how often:
  _____
- Does your child take any vitamins, supplements?…….. ☼Yes ☼No
  Please list:
  _____
- Has your child ever had an allergic reaction to:(if yes, please describe)
  _____

Aspirin or Ibuprofen	☼Yes ☼No	Codeine	☼Yes ☼No
Penicillin or other antibiotics	☼Yes ☼No	Sulfa drugs	☼Yes ☼No
Novocaine, Xylocaine or		Foods	☼Yes ☼No
other local anesthetics	☼Yes ☼No	Latex	☼Yes ☼No
Other			

_____

- Does your child use any complementary or alternative medicines or supplements? ☼Yes ☼No

Please list _____

- Does your child have any mental or physical disability?…… ☼Yes ☼No

If so, please explain _____

- Does your child have any disease, condition or problem not listed above that you think we should know about?_____
- What are her/his hobbies or interest?
  _____

Consent:

1. The undersigned hereby authorizes the taking of x-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Dr. Sina to make a thorough diagnosis of your child's dental needs. And these photographs and/or xrays can be published or displayed in my office or website.
2. I also authorize Dr. Sina to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment of my child.
3. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that Dr. Sina choose and employ such assistance as deemed fit to provide recommended treatment.

_____

Parent (Guardian) Date

SUMMARY/NOTES:

_____

_____

_____ _____

Date Signature of Dr. Maryam Sina