



Patient information

Childs Last Name	First	Middle	Nickname	Sex M F	Date of Birth	Age
Child's Address (Street)		City	State		Zip Code	Phone
Child's School/Preschool					Grade	

Father's Full Name	Mother's Full Name
Father's Address	Mother's Address
City State Zip	City State Zip
Home Phone Cell Phone	Home Phone Cell Phone
Occupation	Occupation
Name of Employer	Name of Employer
Work Phone	Work Phone
Dental Insurance Company	Dental Insurance Company
Social Security Number/ ID	Social Security Number / ID
Group # Date of Birth	Group # Date of Birth
E-Mail	E-Mail

Do Father, Mother and Child all live together?		
If Parents cannot be reached, Friend or Relative to Notify should an emergency arise. Name Relationship		Phone
Has any member of your family been a patient in this office YES NO	Name of Siblings	How did hear about us
Family's General Dentist	Date of Child's last exam and cleaning and name of Dentist	

Consent and Assignment for the Treatment of a Minor

The undersigned hereby authorizes Dr. Amna Shebani and Associates (Dentistry for Children) to perform the examination and, after explanation, the necessary dental services and those methods she deems appropriate in her professional judgment for the care of the above-named child. This authorization includes the release of my child's medical records if deemed necessary for the proper care of my child. I further authorize that my insurance benefits be paid directly to the dentist and I understand that I am financially responsible to the dentist for all the charges not covered by my insurance. The consent shall remain in full force and effect until cancelled by either party.

Signature _____ Date _____

Relationship to Child

Dentistry for Children

Childs Last Name First Middle Nickname Date of Birth Age

--	--	--

1. Has child ever been examined by another dentist? _____
Previous dentist _____ Date _____
2. Has child complained about dental problems? _____

3. Any unhappy dental experiences _____

4. Any injuries to mouth, teeth, head? _____

5. Any mouth habits – thumb sucking, nail biting, mouth
Breathing, nursing bottle habits, pacifier, etc? _____

6. Any unusual speech habits? _____

7. Any missing or extra teeth? _____

8. Have missing teeth been replaced? _____

9. Orthodontic appliances or braces worn now or ever
Been worn? _____
10. Unfavorable reaction to anesthesia? _____

1. Purpose of this visit _____

2. Do you desire complete dental services for the child? _____

3. Child's attitude to dentistry _____
Normal Shy Apprehensive Frightened
4. Does your child brush teeth daily? _____

5. Do you assist child with tooth brushing? _____

6. Is fluoride taken? _____

Child's Physician	Address	Phone
Date of Last Physical Examination	Results	

- | | | | | | |
|----------------------------------------------------------------------|-----|----|---------------------------------------------------------------------------|-----|----|
| | Yes | No | | Yes | No |
| 1. Is child under care of physician now? _____
_____ | | | 7. Are there other allergies: food, pollen, animals, dust? _____
_____ | | |
| 2. Is child receiving any medication or drugs? _____
What? _____ | | | 8. Does child have physical coordination problems? _____
_____ | | |
| 3. Is there any excessive bleeding when cut? _____
_____ | | | 9. Are there any emotional problems? _____
_____ | | |
| 4. Has child ever been hospitalized? _____
_____ | | | 10. Are your child's vaccinations up to date? _____
_____ | | |
| 5. Has child ever had surgery? _____
_____ | | | 11. Has your child ever had a blood transfusion? _____
_____ | | |
| 6. Is there any allergy to penicillin or other drugs? _____
_____ | | | 12. Is your child adopted? _____
Does he/she know? _____ | | |

- HAS YOUR CHILD HAD ANY HISTORY OF, OR DIFFICULTY WITH ANY OF THE FOLLOWING?**
- | | | | | | | |
|----------------|----------------|----------------|--------------------|--------------------|-----------|-----------------|
| Heart | Cerebral Palsy | Mitral Valve | Artificial bone | Tourette Syndrome | Cortisone | |
| Hepatitis | Hiv/Aides | Tuberculosis | Drug/Alcohol abuse | Mental Retardation | Asthma | Rheumatic Fever |
| Diabetes | ADD/ADHD | Psyc Treatment | Anemia | Epilepsy Handicapi | Cancer | Thyroid |
| Fever Blisters | Hemophilia | Hearing | Bulimia | Growth disorder | Sinus | Tuberculosis |

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed _____

I CERTIFY THAT I AM THE DULY AUTHORIZED AGENT OF THE PATIENT AND THAT I HAVE READ AND I UNDERSTAND THE ABOVE QUESTIONS. I WILL NOT HOLD DR. AMNA SHEBANI OR HER ASSOCIATES, OR ANY MEMBER OF HER STAFF, RESPONSIBLE FOR ANY ERRORS OR OMMISIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

SIGNATURE _____ DATE _____

RELATIONSHIP TO CHILD _____