Forever Smiles Pediatric Dentistry
Dr. Leyla Abazari, D.D.S, M.S.D
Diplomat, American Board of Pediatric Dentistry

Patient Information:

Child's Full Name_____ Birthdate_____ Age_____ Sex (M) (F)

Nickname (if any)_____Who may we thank for your referral? _____

PRIMARY PERSON RESPONSIBLE FOR ACCOUNT

Name: _____ DOB:_____

Home address: _____
Street Address Apt / Unit City State zip

Home PH.: _____ Cell PH.: _____

May we contact you via: WK [ ] CELL [ ] HM [ ] [ ] E- Mail:_____

SS#:_____ DL#_____

Relationship to child: Mom [ ] Dad [ ] other:_____

SPOUSE / OTHER PARENT /LEGAL GUARDIAN INFORMATION

Name: _____ DOB:_____

Home address: _____
Street Address Apt / Unit City State zip

Home PH.: _____ Cell PH.: _____

May we contact you via: WK [ ] CELL [ ] HM [ ] [ ] E- Mail:_____

Employer: _____ Job Title: _____

SS#:_____ DL#_____

Relationship to child: Mom [ ] Dad [ ] other:_____

Parent(s) are: Married Divorced Single Widowed Partners
Child lives with: _____

INSURANCE INFORMATION

Policy Owner's Name _____ Insurance name: _____

Employer: _____ Job Title:_____

Birthdate_____ SSN or Alternate ID #_____ Group #_____

Secondary Insurance _____Policy Owner's Name _____ Relationship to Child_____

Birthdate_____ SSN or Alternate ID #_____ Group #_____

Social History

Name of Child _____

What is your child most interested in? _____

Name of Brothers/Sisters_____ Is your Child adopted? (Y) (N)

Name of pets_____ Child's school_____

Reason for today's visit_____

How can we make this appointment a positive experience for your child? _____

Favorite movie and character_____

Name of Child's Pediatrician_____ Office Phone_____

Name of Child's previous dentist_____ Office Phone ( ) _____X-rays taken (Y) (N)

Health History

Y	N	Allergies (If YES, see below)
Y	N	Congenital Heart Problems
Y	N	Heart Murmurs
Y	N	Premature Birth
Y	N	Growth / Development
Y	N	Down syndrome
Y	N	Autism
Y	N	ADHD/ ADD
Y	N	Asthma / Pneumonia
Y	N	Cystic Fibrosis
Y	N	Tuberculosis
Y	N	Anemia
Y	N	Hemophilia / Blood Disorders
Y	N	Easily bruises
Y	N	Skin Problems / Cold Sores

Other _____

Y	N	Hearing Impaired
Y	N	Bone Disorder
Y	N	Cancer / Malignancy
Y	N	Diabetes / Endocrine
Y	N	Brain Injury
Y	N	Epilepsy / Seizure
Y	N	Cerebral Palsy
Y	N	Hepatitis / Liver Disease
Y	N	GI (stomach, Intestinal)
Y	N	Bladder Problems
Y	N	Extremities / Arthritis / Join Problems
Y	N	Emotional / Behavioral Problems
Y	N	School Problem / Depression / Anxiety
Y	N	Hospitalizations / Surgeries
Y	N	Earaches / Infections

If answered yes (Y) to any of the above questions, please explain further_____

Has your child had any unfavorable reactions to drugs, antibiotics, or anesthetic? (Y) (N) If yes, please list and explain_____

Is your child currently taking any prescription or over the counter MEDICATIONS? (Y) (N) If yes, please list and explain_____

Is your child protected by immunization? _____(Y) (N) Is your child taking any supplement fluoride? (Y) (N)

Does your child have any ALLERGIC REACTIONS to (please circle all that apply: No Known Allergies

Medication Anesthetic Latex/Rubber Pollen/Dust /Animals (dogs/cats) Acrylic Dyes/Coloring Food Other, please list_____

_____

Dental History

Is this your child's first visit? (Y)(N) Date of last visit_____ How was his/her experience? _____

Has your child had any injuries to teeth, mouth or head? (Y) (N) If yes, please explain_____

Does your child currently use a bottle? (Y) (N) If yes, how often during the day?_____

Is the bottle used at night? (Y) (N) What do you put in the bottle?_____

Does your child currently nurse? (Y) (N) How does your child brush his/her teeth per day?_____ Do you help? (Y) (N)

How often does your child floss?_____ Do you floss your child's teeth? (Y) (N)

Does your child have any of the following habits (past or present; please circle all which apply)? Thumb/finger-sucking Snoring Pacifier Nail Biting Lip-sucking

Mouth breathing Teeth-Grinding Bottle-feeding Other, please list_____

Permission of parent or guardian is necessary for dental treatment of a minor. I understand that the information I have given is correct to the best of my knowledge and it is my responsibility to inform the office of any changes in my child's health status. I authorize the dental staff of Forever Smiles Pediatric Dentistry and Dr. Abazari to perform any necessary dental services my child may need. I understand by signing this form, I am accepting all responsibility for full payment of services rendered regardless of insurance coverage. I further understand that all payments are due and payable on the day services are rendered.

Parent/Guardian Name: _____ Date:_____

Signature of Parent/Guardian:_____ Doctor's Signature:_____