North Jefferson Pediatric Dentistry

www.amyparvindmd.com

TELL US ABOUT YOUR CHILD

Date:_____

Please complete each line below:

Full Name:_____
Last First MI

Preferred Name: _____ Male ❑ Female ❑ Birthdate: _____ Age: ____

Address: _____ City_____ St_____ Zip_____ Home Phone: _____

Mailing Address: _____City_____ St_____ Zip_____

School: _____ Grade: _____

Hobbies: _____ Siblings: _____

Do you have siblings who are patient's of Dr. Amy's? _____

Whom may we thank for referring you: ❑ Phone book ❑ Patient _____ ❑ Dr. _____ ❑ Other _____
❑ Bham Parent Magazine ❑ Internet

Parent's Information

(Guardian/Foster/Relative)

Father's Name: _____

Street Address:_____

City_____ State_____ Zip_____

Mailing Address:_____

City_____ State_____ Zip_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

Soc. Sec. # _____

DL #_____ Birthday_____

Email Address_____

Employer_____

Occupation_____

(Guardian/Foster/Relative)

Mother's Name: _____

Street Address:_____

City_____ State_____ Zip_____

Mailing Address:_____

City_____ State_____ Zip_____

Home Phone: _____

Work Phone: _____

Cell Phone: _____

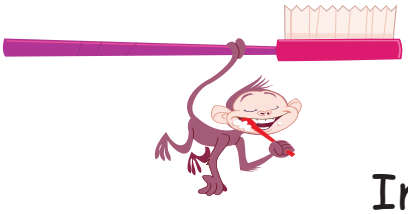
Soc. Sec. # _____

DL #_____ Birthday_____

Email Address_____

Employer_____

Occupation_____



Insurance Information

Insured's Name: _____

Relationship to Patient:_____

Insured's Birthdate:_____Soc. Sec. #_____

Insurance Company Name_____

Policy Number:_____

Group Number: _____

Employer: _____

Insured's Name: _____

Relationship to Patient:_____

Insured's Birthdate:_____Soc. Sec. #_____

Insurance Company Name_____

Policy Number:_____

Group Number: _____

Employer: _____

Dental History

What is the primary reason for today's visit? _____

Is the child currently in pain? _____

Previous / Present Dentist: _____ Date of last visit to dentist: _____ For what service? _____

Were x-rays taken? If so, at what office? _____

Has child complained about any dental problems? _____

_____

Does child brush teeth daily? Yes ❑ No ❑ Does child floss teeth daily? Yes ❑ No ❑

Name of Toothpaste: _____

Is Fluoride taken in any form: Yes ❑ No ❑ If yes, what form: _____

Any injuries to mouth, teeth, head? Yes ❑ No ❑ Date: _____

If yes, please describe: _____

_____

Any unhappy dental experiences? Yes ❑ No ❑ _____

Any mouth habits: Yes ❑ No ❑ *(Circle)* Thumb/finger sucking, pacifier, sleeping with bottle/sippy cup, clenching/grinding, mouth breathing, speech problems, other

Medical History

Child's Physician: _____ Phone: _____

Date of last physical examination: _____ Results: _____

List any medications (prescription, non-prescription or herbal): / reason prescribed: _____

_____

Strattera Yes ❑ No ❑ Latex Allergies Yes ❑ No ❑

List Drug Allergies _____ List Seasonal Allergies _____ List Other Allergies _____

List Hospitalization: _____ List Surgeries: _____

Does your child require antibiotic pre-medication for dental work: Yes ❑ No ❑

Does child have or ever had any of the follow diseases, medical conditions or procedures? If yes, please check (✓).

❑ Subacute Bacterial Endocarditis
❑ Heart Murmur
❑ Congenital Heart Defect
❑ Artificial Heart Valves
❑ Rheumatic Fever
❑ Scarlet Fever
❑ Kawasaki Disease
❑ Artificial Bones/Joints/Implants
❑ Chemotherapy
❑ Blood Transfusions
❑ Cancer/Tumors

❑ Radiation
❑ Mononucleosis
❑ Tonsillitis
❑ Mumps/Measles
❑ Chicken Pox/Shingles
❑ Tuberculosis TB
❑ Asthma/Difficult Breathing
❑ Respiratory Problems
❑ Liver/Kidney/Organ Problems
❑ Hepatitis
❑ Stomach Problems/Reflux

❑ Thyroid Problems
❑ Diabetes/Hypoglycemia
❑ Abnormal Bleeding
❑ Sickle Cell
❑ Hemophilia
❑ Leukemia
❑ Anemia
❑ HIV+/AIDS/ARC
❑ High/Low Blood Pressure
❑ Chromosomal Disorders
❑ Cerebral Palsy

❑ Birth Defects
❑ Cleft Lip Palate
❑ Hearing Problems
❑ Psychiatric Problems
❑ Hyperactive/ADD
❑ Autism
❑ Fainting/Seizures/Epilepsy
❑ Severe Frequent Headaches
❑ Arthritis
❑ Jaw Problems TMJ/TMD
❑ Pregnancy

Please list any other medical condition(s) child has or ever had _____

_____

I _____ hereby authorize assignment of my insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. In the event of non-payment, the parent and/or guardian agrees to bear the cost of collection and our court cost including reasonable legal fees not to exceed 50% of the unpaid balance.

Signature: _____ Date: _____ Relationship to patient _____

Emergency Contacts

(Other than Parent(s)/Guardian(s))

Name: _____ Name: _____

Relationship: _____ Relationship: _____

Phone #: _____ Phone #: _____