

**DANVILLE PEDIATRIC DENTISTRY**  
**OZZIE JAFARNIA, DDS**

**Patient Information**

Childs Name \_\_\_\_\_ Nickname \_\_\_\_\_ Sex (M) (F)  
 Purpose of visit \_\_\_\_\_ Concerns \_\_\_\_\_ Birthdate \_\_\_\_\_  
 Name of brothers/sisters \_\_\_\_\_ Is your child adopted?(Y) (N)  
 Child's interests \_\_\_\_\_ Name of Pets \_\_\_\_\_  
 Does your child have any special needs? \_\_\_\_\_ Any phobias? \_\_\_\_\_  
 Child's learning: slow average accelerated Child's School: \_\_\_\_\_  
 Whom may we thank for referring you? \_\_\_\_\_

**Health History**

Child's Pediatrician \_\_\_\_\_ Phone number \_\_\_\_\_ Last Exam \_\_\_\_\_  
 Is your child under a physician's care? (Y) (N) If yes, please list \_\_\_\_\_  
 Is your child taking any medications (including over the counter)? (Y) (N) \_\_\_\_\_  
 Is your child allergic to any medications? (Y) (N) If yes, please list \_\_\_\_\_  
 Any history of hospitalization or surgery? (Y) (N) If yes, when? \_\_\_\_\_  
 Does your child have allergic reaction to: (if yes; please check all that apply)  
 \_\_\_Peanut/Tree Nuts \_\_\_Soy \_\_\_Latex/Rubber \_\_\_Pollen/Dust \_\_\_Anesthetic  
 \_\_\_Eggs \_\_\_Metals \_\_\_Animals \_\_\_Berries \_\_\_Acrylic  
 \_\_\_Milk \_\_\_Wheat \_\_\_Dyes/Coloring \_\_\_Other \_\_\_\_\_

Has your child had a history of the following?

ADHD/ADD	Y N	Cardiac Disease/Heart	Y N	Hepatitis	Y N
Anemia	Y N	Cerebral Palsy	Y N	Immune Disorder	Y N
Allergies	Y N	Chemo/Radiation Therapy	Y N	Kidney	Y N
Arthritis/Joint	Y N	Cystic Fibrosis	Y N	Liver	Y N
Asthma	Y N	Delayed Development	Y N	Murmur	Y N
Allergies to Meds	Y N	Depression/Anxiety	Y N	Muscular Disorder	Y N
Autism	Y N	Diabetes	Y N	Premature Birth	Y N
Bladder	Y N	Down's Syndrome	Y N	Rheumatic Fever	Y N
Bleeding Disorder	Y N	Earaches/Infections	Y N	Speech Disorder	Y N
Bone Disorder	Y N	Eating Disorder	Y N	Sinusitis	Y N
Brain Injury	Y N	Emotional/School Problems	Y N	TMJ Problems	Y N
Bruising	Y N	Epilepsy/Seizure	Y N	Tuberculosis	Y N
Cancer/Malignancy	Y N	Hearing Impaired	Y N	Visual Impaired	Y N

Other: \_\_\_\_\_

**Dental History**

Is this your child's dental first visit? (Y)(N) If no, previous dentist? \_\_\_\_\_ Phone \_\_\_\_\_  
 Date of last visit \_\_\_\_\_ How was his/her experience? \_\_\_\_\_ X-rays taken? (Y)(N)  
 Child's attitude toward the dentist or dental care \_\_\_\_\_  
 Has your child had any injuries to teeth, mouth or head? (Y)(N) Please describe: \_\_\_\_\_  
 Has your child done any of the following (past or present)? Please circle:

Thumb/finger sucking	Pacifier	Nail biting	Lip sucking	Mouth-breathing
Teeth Grinding	Snoring	Nursing	Bottle feeding	

Is your water fluoridated? (Y)(N) Does your child take fluoride supplements?(Y)(N) Fluoride Toothpaste? (Y)(N)  
How often does your child brush his/her teeth? \_\_\_\_\_ With adult supervision? (Y)(N) Floss ? (Y)(N)  
How may we help make this visit a positive experience for your child? \_\_\_\_\_

### General Information

Father (full name) \_\_\_\_\_ SSN \_\_\_\_\_ Birthdate \_\_\_\_\_  
Mother (full name) \_\_\_\_\_ SSN \_\_\_\_\_ Birthdate \_\_\_\_\_  
Parent(s) are: Married Divorced Single Widowed Partners Child lives with: \_\_\_\_\_  
Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_

Father's Employer \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
Mother's Employer \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Business Address \_\_\_\_\_ Work Phone \_\_\_\_\_  
E-mail Address \_\_\_\_\_ Person Financially responsible \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
How would you like us to contact you? Home Work Cell E-mail

The permission of parent or guardian is necessary for dental treatment of a minor. I give permission to Dr. Ozzie and staff to use such measures as deemed necessary in their professional judgment to render the best dental treatment for my child. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform the office of any changes in my child's health status.

SIGNATURE \_\_\_\_\_ Relationship \_\_\_\_\_

### Insurance Information

Primary Insurance Company \_\_\_\_\_ Phone Number \_\_\_\_\_  
Subscriber \_\_\_\_\_ Birthdate \_\_\_\_\_ Group Number \_\_\_\_\_  
Secondary Insurance Company \_\_\_\_\_ Phone Number \_\_\_\_\_  
Subscriber \_\_\_\_\_ Birthdate \_\_\_\_\_ Group Number \_\_\_\_\_

As a courtesy to our patients, we will file your insurance claim with the insurance company listed above for treatments your child receives. However, in the event the insurance company, for any reason, does not pay, the balance will become your responsibility, and will be billed directly to you. You understand that this contract is with Danville Pediatric Dentistry and yourself, and you are responsible for all charges on the account. Also, you have received a copy of Danville Pediatric Dentistry's Financial Agreement and agree to all policies.

SIGNATURE OF RESPONSIBLE PARTY \_\_\_\_\_  
Relationship \_\_\_\_\_ Date \_\_\_\_\_

#### *For Office Use Only:*

We attempted to obtain written acknowledgement of receipt of our NOTICE OF PRIVACY PRACTICES, but acknowledgment could not be obtained because of:

\_\_\_\_ Individual refused to sign \_\_\_\_ Communication barriers prohibited \_\_\_\_ Emergency Situation

\_\_\_\_ Acknowledgement not returned by parent. HIPAA information given

Medical and Dental History Reviewed Verbally with Parent/Guardian for Patient Named Above \_\_\_\_ Initial