Pediatric Specialist
Ozzie Jafarnia, DDS
Dana Kapp, DMD
Edirin Sido, DMD

General Dentist for Teens
Maurissa Kiefer, DDS

Patient Information

Patient name_____ Nickname_____Sex ☐M ☐F
Purpose of visit_____ Concerns_____ DOB____/_____/____
Name of brother(s)/ sister(s)_____ 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?_____
How may we help make this visit a positive experience for your child?_____

Health History

Child's Pediatician_____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 a history of allergic reactions to any of these (please check all that apply)?

☐Acrylic	☐Antibiotics	☐Eggs	☐Milk	☐Soy
☐Anesthetic	☐Berries	☐Latex/Rubber	☐Peanut/Tree Nuts	☐Wheat
☐Animals	☐Dyes/Coloring	☐Metals	☐Pollen/Dust	☐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	Hearning Impared	☐Y ☐N	Visual Impaired	☐Y ☐N

Other:_____

Dental History

Is this your child's first dental visit? ☐Y ☐N If no, previous dentist?_____ Phone_____
Date of last visit___/___/___ How was the experience?_____ Child's attitude towards dentist_____
Were x-rays taken? ☐Y ☐N Has your child had any dental, mouth, or head injuries?_____

Do any of the following habits apply to your child?

☐**Past** ☐**Present** Bottle feeding	☐**Past** ☐**Present** Nail biting	☐**Past** ☐**Present** Snoring
☐**Past** ☐**Present** Lip sucking	☐**Past** ☐**Present** Nursing	☐**Past** ☐**Present** Teeth grinding
☐**Past** ☐**Present** Mouth breathing	☐**Past** ☐**Present** Pacifier	☐**Past** ☐**Present** Thumb/Finger sucking

Is your water fluoridated? ☐Y ☐N Does your child take fluoride supplements? ☐Y ☐N Fluoride toothpaste? ☐Y ☐N
How often does your child brush their teeth? ☐None ☐1X ☐2X With supervision? ☐Y ☐N Floss? ☐Y ☐N

Dental History

Parent 1_____ Sex ☐M ☐F SSN_____ DOB____/____/____
Parent 2_____ Sex ☐M ☐F SSN_____ DOB____/____/____
Parent(s) are: ☐Divorced ☐Married ☐Partners ☐Single ☐Widowed Child lives with_____
Person financially responsible _____ Email address_____

Home address_____ Primary phone_____
City_____ State_____ Zip code_____ ☐Cell ☐Home

Parent 1 Employer_____ Cell phone_____
Business Address_____ Work phone_____
Parent 2 Employer_____ Cell phone_____
Business Address_____ Work phone_____

Emergency contact_____ Relationship_____ Phone_____

The permission of a parent or guardian is necessary for the dental treatment of a minor. I give permission to Danville Pediatric Dentistry & Orthodontics 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_____ Date____/_____/_____

Insurance Information

Primary insurance company _____ Phone number_____
Subscriber_____ DOB____/____/____
Subscriber ID_____ Group number_____

Secondary insurance company _____ Phone number_____
Subscriber_____ DOB____/____/____
Subscriber ID_____ 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 & Orthodontics and yourself, and you are responsible for all charges on the account. Also, you have received a copy of the Danville Pediatric Dentistry & Orthodontics financial agreement and agree to all policies.

SIGNATURE OF RESPONSIBLE PARTY_____
Relationship_____ Date____/_____/_____

For office use only
We attempted to obtain written acknowledgment 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. HIPPA information given

Medical and Dental History Reviewed Verbally with Parent/ Guardian for Patient Named Above _____.
(Initial)