DANVILLE PEDIATRIC DENTISTRY
OZZIE JAFARNIA, DDS

Patient Information

Patient 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	____Antibiotics	____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 _____
City _____ Zip Code _____

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 _____

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