WELCOME KIDS!

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our priactice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!

pediatric dentistry
Dr. Farah N Khan DDS, PC

Tell Us About Your Child

Today's Date: _____
Child's Name: _____
Last *First* *Middle*
Birthdate: ____ / ____ / ____ Child's Age: _____
Nickname: _____ ☐ Male ☐ Female
School: _____ Grade: _____
Siblings: _____
Home Phone: ( ) _____
Social Security #: _____
Home Address: _____
Apt. #
_____
City *State* *Zip Code*

General Information

Who is accompanying the child today? _____
Name: _____ Relation: _____
Do you have legal custody of the child? ☐ Yes ☐ No
Who may we thank for referring you? _____
Previous Dentist: _____ Last visit: _____

Emergency Contact:
Name: _____ Phone #: ( ) _____
Address: _____
_____
City *State* *Zip Code*
Primary Language Spoken: _____

Parent's Information

Person responsible for account: _____
Mother's Name: _____ DOB: _____
☐ Mother/Father ☐ Step-Mother/Father ☐ Guardian
Address: (if different from Child's): _____
_____
SS #: _____
Work #: ( ) _____ Cell #: ( ) _____
Email Address: _____
Employer: _____
Employer's Address: _____
_____
City *State* *Zip Code*
If you have Dental Insurance for your Child, please fill out below:
Insurance Co. Name: _____
ID #: _____ Group #: _____

Parent's Marital Status: _____
Father's Name: _____ DOB: _____
☐ Mother/Father ☐ Step-Mother/Father ☐ Guardian
Address: _____
_____
SS #: _____
Work #: ( ) _____ Cell #: ( ) _____
Email Address: _____
Employer: _____
Employer's Address: _____
_____
City *State* *Zip Code*
If you have Dental Insurance for your Child, please fill out below:
Insurance Co. Name: _____
ID #: _____ Group #: _____

Parent's Information

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance company does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

_____ _____
Signature of Parent/Guardian *Date*

Dental History

Why did you bring the child to see the dentist today?_____

_____

_____

Has the child ever taken any diet pills such as Phen-Fen? ❑ Yes ❑ No
(Also known as Redux or Pondimin) If so, when? _____

Is the child currently in pain? ❑ Yes ❑ No

Does the child require antibiotics before dental treatment? ❑ Yes ❑ No

Has the child ever had a serious/difficult problem associated with previous dental work? ❑ Yes ❑ No

Is the child's water fluoridated? ❑ Yes ❑ No

Is the child taking fluoridated supplements? ❑ Yes ❑ No

Has the child ever had any pain/tenderness in in his/her jaw joint (TMJ/TMD)? ❑ Yes ❑ No

Does the child brush his/her teeth daily? ❑ Yes ❑ No

Does the child floss his/her teeth daily? ❑ Yes ❑ No

Child's Physician:_____

Phone #: ( )_____ Date of Last Visit: _____

Is the child currently under the care of a physician? ❑ Yes ❑ No

Please describe the child's current physical health:

❑ Good ❑ Fair ❑ Poor

Please list any drugs that the child is currently taking: _____

_____

_____

Please list all drugs that the child is allergic to:

_____

_____

Y N Allergic to Latex
Y N Allergic to Nickel
Y N Allergic to Metals
Y N Allergic to Plastic

Medical History

Has the child experienced any of the following medical problems?

Y N Abnormal Bleeding/ Hemophilia
Y N ADD/ADHD
Y N AIDS/HIV+
Y N Anemia
Y N Any Hospital Stays/Operations?
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Cancer
Y N Chicken Pox
Y N Congenital Heart Defect
Y N Convulsions
Y N Diabetes
Y N Epilepsy
Y N Exposed to HIV, but Neg.
Y N Handicaps/Disabilities
Y N Hearing impairment
Y N Heart Murmur
Y N Hepatitis
Y N High Blood Pressure
Y N Hives
Y N Kidney Problems
Y N Liver Problems
Y N Low Blood Pressure
Y N Lupus
Y N Measles
Y N Mitral Valve Prolapse
Y N Mononucleosis
Y N Prosthetics
Y N Rheumatic Fever
Y N Scarlet Fever
Y N Skin Rash
Y N Tuberculosis (TB)

Are the child's immunizations current? ❑ Yes ❑ No

Is there anything you would like to discuss with the Doctor in Private? ❑ Yes ❑ No

Please discuss any serious medical problems the child experiences/ed:

_____

_____

Does/did the child experience any of the following?

Y N Breast Fed
Y N Chewing on Objects
Y N Clenching/Grinding Teeth
Y N Lip Sucking/Biting
Y N Mouth Breather
Y N Nail Biting
Y N Nursing Bottle Habits
Y N Speech Problems
Y N Thumb/finger Sucking
Y N Tongue/Cheek Sucking
Y N Tongue Thrust
Y N Used Pacifier

our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control made by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____
Signature of Parent or Guardian Date

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

_____ _____
Signature of Dentist Date

Dentist's Comments: _____

_____

Medical Histroy Update

Has there been any change in your child's health status since their last visit? ❑ Yes ❑ No

If Yes, Please explain: _____

_____

Has there been any change in your child's health status since their last visit? ❑ Yes ❑ No

If Yes, Please explain: _____

_____

_____
Parent /Guardian Signature Date

_____
Dentist Signature Date

_____
Parent /Guardian Signature Date

_____
Dentist Signature Date