Arleen Azar-Mehr, D.D.S., M.S.

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Today's Date_____

About Your Child

Child's Name:_____**Nickname:**_____□**Female** □**Male** **Date of Birth:** __/__/__ **Age:**_____**Grade:**_____
Child's Address:_____Unit #_____City:_____State:____Zip:_____SS #:_____
Child's Home #: (____)_____School:_____Hobbies/Sports:_____

General Information

Child's General Dentist:_____Dentist's Phone #:(____)_____Dentist's Address:_____
Who is bringing the child today? Name:_____Relation:_____Do you have legal custody of this child? □Yes □No
Whom may we thank for referring you?_____Other Siblings:_____Child's Email:_____
Relative or Friend not living with you:_____Phone #:(___)_____Address:_____

Parents Information

Who is responsible for account? □Mother □Father □Guardian Parent's Marital Status: □Single□Married□Divorced□Separated□Partnered□Widowed

□ **Father** □ **Stepfather** □ **Guardian** **Name:**_____**Date of Birth:** ___/___/___ **DL#:**_____
Home #:(____)_____ Cell #:(___)_____Wk #:(___)_____Email:_____
Address: (If different than Child's)_____City:_____State:____Zip:_____□Own □Rent How Long?___
Employer:_____Position:_____Employer Address:_____How long?_____
Dental Insurance Coverage □ Yes □ No Insurance Co.Name:_____Insured's Name:_____
Insurance Co. Address:_____City:_____State:____Zip:_____Insurance Phone #:_____
SS #:_____Insured's ID #:_____Group #:_____

□ **Mother** □ **Stepmother** □ **Guardian** **Name:**_____**Date of Birth:** ___/___/___ **DL#:**_____
Home #:(____)_____ Cell #:(___)_____Wk #:(___)_____Email:_____
Address: (If different than Child's)_____City:_____State:____Zip:_____□Own □Rent How Long?___
Employer:_____Position:_____Employer Address:_____How long?_____
Dental Insurance Coverage □ Yes □ No Insurance Co.Name:_____ Insured's Name:_____
Insurance Co. Address:_____City:_____State:____Zip:_____Insurance Phone #:_____
SS #:_____Insured's ID #:_____Group #:_____

Authorization

I agree and accept that this office reserves the right to verify credit status of potential patients and/or parents prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered. I understand I am responsible for paying any co-payment and deductibles my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits and, I assign directly to the doctor, all insurance benefits otherwise payable to me. I further authorize the use of my signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian **Date**

Dental & Medical History

What is your main concern for your child?_____

Has your child been evaluated or had orthodontic treatment before?	□ Yes □ No
Does your child require antibiotics prior to dental treatment?	□ Yes □ No
Have there been any injuries to the mouth, teeth, chin or face?	□ Yes □ No
Does your child have any missing or extra teeth?	□ Yes □ No
Does your child brush their teeth daily?	□ Yes □ No
Has your child ever had any pain or tenderness in their jaw joint (TMJ/TMD)?	□ Yes □ No
Have their tonsils or adenoids been removed?	□ Yes □ No
Does your child floss their teeth daily?	□ Yes □ No
Has puberty begun?	□ Yes □ No
Has menstruation begun? (If Female)	□ Yes □ No
Are your child's immunizations current?	□ Yes □ No
Is there anything you would like to discuss with the Doctor in private?	□ Yes □ No
Has your child ever taken any diets pills, such as Phen-Fen?	□ Yes □ No

(Also known as Redux or Pondimin.) If so when? _____

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

Child's Physician:_____Phone #:(___)_____Date of Last Visit:_____

Please describe your child's current physical heath: □ Good □ Fair □ Poor

Please list any musical instruments your child plays:_____

Please list all drugs that your child is currently taking?_____

Please discuss any serious medical problems your child has had:_____

Is your child allergic to: Latex Y N Nickel or Metal Y N Plastic Y N Other:_____

Has your child experienced any of the following medical problems?

Abnormal Bleeding	Y N	Heart Murmur	Y N
ADD or ADHD (circle one please)	Y N	Hemophilia	Y N
AIDS or HIV (circle one please)	Y N	Hepatitis	Y N
Artificial Bones/Joints/Valves	Y N	Kidney Problems	Y N
Asthma	Y N	Liver Problems	Y N
Cancer	Y N	Mitral Valve Prolapse	Y N
Congenital Heart Defect	Y N	Prosthetics	Y N
Diabetes	Y N	Rheumatic Fever	Y N
Disabilities	Y N	Scarlet Fever	Y N
Epilepsy	Y N	Seizures	Y N
Handicaps	Y N	Sickle Cell Disease	Y N
Hearing Impairment	Y N	Tuberculosis (TB)	Y N

Does or did your child have any of the following habits?

Breast Fed	Y N	Nursing Bottle Habits	Y N
Clenching or Grinding Teeth	Y N	Speech Problems	Y N
Lip Sucking or Biting	Y N	Thumb or Finger Sucking	Y N
Mouth Breather	Y N	Tongue Thrust	Y N
Nail Biting	Y N	Used a Pacifier	Y N

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that 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/orthodontic services my child may need.

Signature of Parent or Guardian **Date**

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

Signature of Dentist Date

Dentist's Comments: _____

Has there been any change in your child's health status since their last visit? □ Y □ N

If Yes, please explain:_____

Parent Guardian Signature **Date**

Dentist Signature Date

Has there been any change in your child's health status since their last visit? □ Y □ N

If Yes, please explain:_____

Parent or Guardian Signature **Date**

Dentist Signature Date