

Shahnaz Bonyanpoor, D.D.S | Laura McCormack, D.D.S  
Children's Dental Specialists  
62 Corporate Park, Suite 135 | Irvine CA | 92606  
(949) 252-9950

## Welcome

Patient's Name \_\_\_\_\_  Male  Female

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

Parent/Guardian Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Parent/Guardian Social Security No. \_\_\_\_\_

Spouse/Parent Name \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_ Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

E-mail \_\_\_\_\_

How would you like us to confirm your appointment? (Circle all that apply)

**Home Phone | Work Phone | Cell Phone | E-mail | Text Message #** \_\_\_\_\_

Do you have dental insurance? YES NO | If yes, please provide us the following:

Dental Insurance Co. \_\_\_\_\_ Policy # \_\_\_\_\_

Name of subscriber/ primary person on insurance: \_\_\_\_\_

*Is the insurance through an employer? YES NO | If yes, please provide the following:*

*Employer Name:* \_\_\_\_\_ *Phone:* \_\_\_\_\_ *City & State* \_\_\_\_\_

In case of an emergency, please notify: Name \_\_\_\_\_ Phone \_\_\_\_\_

Who may we thank for introducing our office to your family? \_\_\_\_\_

### **Informed Consent:**

I consent to the diagnostic procedures and treatment by the dentist necessary for proper dental care. I consent to the dentist's use and disclosure of my child's records to carry out treatment, to obtain payment, and for those activities and health care operations that are related to the treatment or payment.

I authorize payment directly to the dentist from my insurance company. I understand that my dental insurance may pay less than the actual bill for services and by signing below I agree to be responsible for payment of all services not paid by my insurance company.

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### Dental & Medical History

Patient's Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

1. Is this your child's first visit to a dentist?.....YES NO  
Please tell us when and where was his/her last dental visit \_\_\_\_\_
2. Were any x-rays taken?.....YES NO
3. When does your child brush his/her teeth?  
 Upon arising  After eating any food  Right after meals  Before going to bed
4. Have any cavities been noted in the past?.....YES NO
5. Does your child have oral habits such as sucking on his/her thumb or on a pacifier? ... YES NO
6. Have there been any injuries to teeth, such as falls, blows, chips, etc?.....YES NO  
If so, please describe \_\_\_\_\_
7. Has your child had any problem with dental treatment in the past?.....YES NO
8. Has your child ever received a local anesthetic?.....YES NO
9. Does your child think there is anything wrong with his/her teeth?.....YES NO
10. Does your child have any health problems and/or challenges?.....YES NO  
If yes, could you please describe \_\_\_\_\_
11. Is your child taking any medication?.....YES NO  
What medication? \_\_\_\_\_
12. Is your child allergic to penicillin, antibiotics or other drugs?.....YES NO
13. Is your child allergic or sensitive to any metals or latex?.....YES NO
14. Does your child have other allergies?.....YES NO
15. Has your child ever been hospitalized?.....YES NO  
Please explain the circumstances of his/her hospitalization \_\_\_\_\_
16. Does your child have heart murmur or any other heart problems? .....YES NO
17. Does your child experience severe or prolonged bleeding?.....YES NO
18. Does your child have or have they tested positive for Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)?.....YES NO
19. Has your child tested positive for hepatitis?.....YES NO
20. Is your child subject to nervous disorders?.....YES NO  
 Fainting  Seizures  Dizziness  Behavioral/Learning Problems
21. Does your child have frequent headaches?.....YES NO
22. Has your child had a history of any of the following?.....YES NO  
(Circle appropriate responses) Diabetes, asthma | kidney infection, rheumatic fever, epilepsy, cerebral palsy, liver problems, congenital birth defects, mental retardation, eyesight problems, cancer, infections, speech impairments, hearing loss.
23. Does your child have a regular pediatrician or physician?.....YES NO  
Name of physician \_\_\_\_\_ Phone \_\_\_\_\_
24. May we communicate with your physician about your child's dental health?.....YES NO

**I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.**

Parent/Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

Dentist's Signature \_\_\_\_\_ Date \_\_\_\_\_