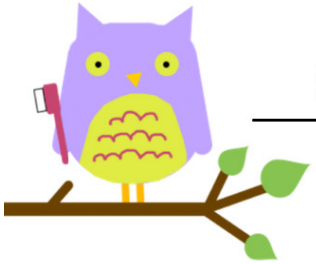
WELCOME KIDS!



Sona J. Isharani, DDS
Board Certified Pediatric Dentist
Pediatric Dentistry with a Mother's Touch

Child's Registration & History

Today's Date:

Child's Name: _____
First Middle Last

Date of Birth: _____ Nickname: _____

Male Female Hobbies _____

Home Address: _____
Street Address

_____
City State Zip Code

Child's Home #: (_____)_____ SS#: _____

School the child attends: _____Grade _____

Who is accompanying the child today?

Name _____ Relation _____
Do you have legal custody of the child? . Yes . No
Whom may we thank for referring you?
_____

Other siblings? _____

Prev. Dentist: _____

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

Person Responsible for the account: _____
Parent's Marital Status: Single Married
Partnered Widowed Divorced Separated

Father Step Father Guardian

Name: _____
First Middle Last

Date of Birth: _____ SSN: _____

Address (if different from child's) Hm # (____)_____

_____

Work #: (____)_____ Cell #: (____)_____

Email: _____

Employer: _____ How Long? _____

Employer's Address: _____

Mother Step Mother Guardian

Name: _____
First Middle Last

Date of Birth: _____ SSN: _____

Address (if different from child's) Hm # (____)_____

_____

Work #: (____)_____ Cell #: (____)_____

Email: _____

Employer:_____ How Long? _____

Employer's Address: _____

Dental Insurance Company: _____ Group #: _____ ID#: _____

Address for Dental Claims: _____
Street Address City State Zip Code

Child's name: _____ Date of Birth: _____ Date: _____

Medical and Dental History

Your child's overall health, as well as any medications that he/she takes, may have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Medical History

Child's Physician: _____
Physician's Address: _____
_____
Date of Last Physical: _____
_____
Is your child up to date on vaccinations? _____

Has your child ever had any of the following?

Asthma	yes . no
Cancer/Tumors	yes . no
Hepatitis	yes . no
HIV/Aids	yes . no
Hemophilia	yes . no
Diabetes	yes . no
Kidney Problems	yes . no
Liver/GI Problems	yes . no
Endocrine Abnormalities	yes . no
Allergies (seasonal)	yes . no
Allergies (food,drug)	yes . no
Explain _____	
Hearing Problems	yes . no
Eye Disorders	yes . no
Breathing/Lung Problems	yes . no
Blood Disorders	yes . no
Adverse Drug Reaction	yes . no
Rheumatic Fever	yes . no
Congenital Heart Defect	yes . no
Congenital Birth Defect	yes . no
Mental/Physical	yes . no
Development Delays	yes . no
Behavioral/Learning Problems	yes . no
Seizures/Epilepsy	yes . no
Social Development Delays	yes . no
Recurrent/Freq. Headaches	yes . no
Tuberculosis	yes . no
Frequent Infections	yes . no
Significant Injuries	yes . no
Explain _____	
Hospitalizations	yes . no
Explain _____	
Abnormal Bleeding	yes . no
History of Blood Transfusion	yes . no
Date _____	
Heart Ailments	yes . no
Heart Murmur	yes . no
Type _____	
Premed Needed	yes . no

Please explain any other medical problems child has _____
_____
_____.

Child's Medications

Please list your child's medications & dosages:
_____
_____
_____
_____

Dental History

What are your main concerns about your child's dental no health? _____
_____
How frequently are your child's teeth brushed? _____
How frequently are your child's teeth flossed? _____
Do you help your child with brushing/flossing? yes . no
Date of last dental visit _____ xrays _____
Previous Dentist _____
How would you describe your last dental experience?
_____
Does your child have a healthy diet? _____
Does your child's family have a history of dental decay or gum disease? yes . no
Is your child's drinking water fluorinated? yes . no
Does your child take fluoride supplement? yes . no
If yes, dosage: _____
Does your child:

Suck thumb/finger/lips/pacifier?	yes . no
Bite/chew nails or hard objects?	yes . no
Grind teeth/clench jaws?	yes . no
Use a bottle/sippy cup?	yes . no
Breast feed/how long? _____	yes . no
Eat/drink after brushing?	yes . no
Brush before bed?	yes . no
Drink more than 1 glass of juice, tea, soda, or sports drink per day?	yes . no
Have a history of dental trauma?	yes . no

Authorization & Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examinations rendered to my child during the period of such dental care to third party payers and/or health that your practitioners. I also consent to any necessary radiographs (x-rays) needed for proper diagnosis.

X _____
Signature of parent/guardian date

Photograph/Video Consent Form

Name of Participant(s): _____Date: _____

I hereby give my permission to **Steven L Hatcher, DDS, PA & Sona J Isharani, DDS** to use any photos/videos of the child(ren) listed above. The photos/videos will only be used for promotional purposes and for the presentation of pediatric patients to other parents who may be considering bringing their children to our practice. These photos/videos may be used on the practice's Facebook fan page, website, or printed materials. I may at any time withdraw my permission for photos or videos of my child(ren).

Signature: _____