Seedling KIDS DENTISTRY

Patient Information

Date _____
Patient Name _____Nickname _____ Sex (M) (F) Birthdate _____
Child's School: _____Grade Level _____ Child's learning: slow average accelerated
Name of brothers/sisters _____Is your child adopted? (Y) (N)
Child's interests _____ _____
Does your child have any special needs? _____ Any phobias? _____
Whom may we thank for referring you to our office? _____

Health History

Child's Pediatrician _____ Phone number _____Address _____
Date of last well-check exam_____
Is your child under a specialist'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	Heart 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

Purpose of dental visit _____Concerns _____
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 ever seen an orthodontist? If yes who and when? _____
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 be a positive experience for your child? _____

General Information

Parent 1 _____ Sex(M)(F)- SSN_____ Birth date_____
Parent 2 _____ Sex (M)(F)-SSN_____ Birth date_____
Parent(s) are: Married Divorced Single Widowed Partners Child lives with: _____

Home Address _____ Home Phone _____
City _____ Zip Code _____

Parent 1's Employer_____ Cell Phone _____
Business Address _____ Work Phone _____
Parent 2's Employer _____ Cell Phone _____
Business Address _____ Work Phone _____
E-mail Address _____ Person Financially responsible _____
Emergency Contact _____ Phone _____
How would you like us to best communicate with you regarding your child? (Select all that apply)
Home Phone _____ Cell Phone_____ Text_____ Email(provide email address) _____

The permission of parent or guardian is necessary for dental treatment of a minor. I give permission to Dr. Noyan Aynechi 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 _____ SSN _____
Subscriber ID: _____ Group Number _____

Secondary Insurance Company _____ Phone Number _____
Subscriber _____ Birthdate _____
Subscriber ID: _____ 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 Seedling Kids Dentistry and yourself, and you are responsible for all charges on the account. Also, you have received a copy of Seedling Kids 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