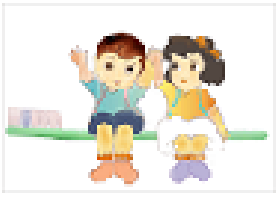
Vienna Pediatric Dentistry, P.C.

Sarah Ganjavi-Rejali D.D.S.

Pediatric Dentist



Today's Date: _____

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely.

Child's Name _____ Sex _____ Age _____

Nickname _____ Date of Birth: _____

School _____ Grade_____

Child's Home Address _____

City _____ State _____ Zip _____ Phone _____

Whom should we thank for the referral _____

Parent or Guardian Information ☐ **Mother** ☐ **Stepmother** ☐**Guardian**

Name _____ Birthdate _____ Email _____
Home Phone _____ Cell Phone _____ Work Phone _____
Employer _____ Occupation _____
SS# _____ DL# _____
Marital Status ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

Parent or Guardian Information ☐ **Father** ☐ **Stepfather** ☐**Guardian**

Name _____ Birthdate _____ Email _____
Home Phone _____ Cell Phone _____ Work Phone _____
Employer _____ Occupation _____
SS# _____ DL# _____
Marital Status ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

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Primary Insurance
Insured's Name _____ Relationship _____
Birthdate _____ SS# _____
Employer _____ Occupation _____
Insurance Company _____ Group # _____ ID #_____
Insurance Company Address _____ City _____ State _____ Zip _____
Deductible _____ Copay _____ Amount already used _____ Max annual benefit _____

Additional Insurance
Insured's Name _____ Relationship _____
Birthdate _____ SS# _____
Employer _____ Occupation _____
Insurance Company _____ Group # _____ ID #_____
Insurance Company Address _____ City _____ State _____ Zip _____
Deductible _____ Copay _____ Amount already used _____ Max annual benefit _____

Please turn over to complete the Health History portion of this form

Dental/Medical Health History (Confidential)

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush? _____
How often does your child floss? _____

Is your child's water fluoridated? ☐ Yes ☐ No
Does your child take fluoride supplements? ☐ Yes ☐ No

Does your child:

Suck Thumb/Finger ☐ Yes ☐ No
Suck/Bite Lip ☐ Yes ☐ No
Bite/Chew Mails ☐ Yes ☐ No
Chew Hard Objects (pencils, etc.) ☐ Yes ☐ No
Grind Teeth ☐ Yes ☐ No
Clench Jaws ☐ Yes ☐ No

Date of last Dental Visit _____
Previous Dentist _____
Address _____
Has your child had difficulty with previous dental visits? ☐ Yes ☐ No

Is your child allergic to or had any reaction to any of the following:

Local Anesthetic ☐ Yes ☐ No
Penicillin ☐ Yes ☐ No
Other Antibiotics ☐ Yes ☐ No
Sulfa Drugs ☐ Yes ☐ No
Latex ☐ Yes ☐ No
Any Metals ☐ Yes ☐ No
Environmental ☐ Yes ☐ No

Other: _____

Has your child ever had any of the following:

Asthma ☐ Yes ☐ No
Handicaps/Disabilities ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Hepatitis ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
HIV/AIDS ☐ Yes ☐ No
Rheumatic Fever ☐ Yes ☐ No
Hemophilia ☐ Yes ☐ No
Congenital Heart Defect ☐ Yes ☐ No
Abnormal Bleeding ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No
Stomach, Liver or Kidney Problems ☐ Yes ☐ No
Confusions/Epilepsy ☐ Yes ☐ No
Autism ☐ Yes ☐ No
Hay Fever/Allergies ☐ Yes ☐ No
Leukemia ☐ Yes ☐ No
ADD/ADHD ☐ Yes ☐ No

Other _____

Child's Physician _____ Phone_____
Address _____
Child's Pharmacy _____ Phone _____
Previous Hospitalizations/Surgeries/Serious Illnesses When?
_____ _____
_____ _____
_____ _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? ☐ **Yes** ☐ **No**
(If yes, please describe) _____
Please explain any medical problems that your child has: _____
_____
_____

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 also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentists or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less that the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Parent/Guardian Signature: _____ Date: _____

Thank you for choosing Vienna Pediatric Dentistry.