Cima Mazar-Atabaki, DMD
Board Certified Pediatric Dentist

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PATIENT INFORMATION

Name____ Nickname____

Date of Birth__________________Age_________Sex__________ Social Security Number___________________________________

Address____ City_____________________________State_____Zip__________

Who is accompanying the child today?
Name____

Relation
☐ Biological ☐ Adopted/Foster ☐ Nanny ☐ Other

PARENT INFORMATION

Parent/Guardians Name______________________________ Driver's License #_______________________________________

Address____ City__________________________State________Zip___________

Home Phone( )__________________________________ Cell Phone( )__________________________________

E-mail____ Work Phone( )__________________________________

DENTAL INSURANCE INFORMATION

PRIMARY COVERAGE

Name of Insured____

Date of Birth____________________SS #_______________________

Employer____

Insurance Co____

Address____

City____________________________State______Zip____________

Phone____

Group/Policy #_________________ I.D. #_____________________

SECONDARY COVERAGE

Name of Insured____

Date of Birth____________________SS #_______________________

Employer____

Insurance Co____

Address____

City____________________________State______Zip____________

Phone____

Group/Policy #_______________ I.D. #_____________________

REFERRAL INFORMATION

Please share with us how you heard about our office...

☐ Sibling(s)_______________ ☐ Friend __________________ ☐ Google ☐ Website ☐ Yelp ☐ Facebook

☐ Pediatrician______________ ☐ Dental Office_____________ ☐ Print Ad_______________ ☐ Community Event___________

☐ School/Daycare___________ ☐ Insurance Co_____________ ☐ Other____

DENTAL HISTORY

What is the primary reason for today's visit? ☐ Cleaning ☐ Trauma/Dental Emergency ☐ Consult for Decay (Cavities)

Has your child ever been to the dentist? ☐ Yes ☐ No
(If Yes) Previous Dentist ______________________

Reason for leaving previous dentist______________________

Date of Last Exam______________ Date of Last X-ray______________

Is your child nervous about previous dental treatment? ☐ Yes ☐ No
(If Yes) Please Describe______________________

Does (Did) your child have any of the following Dental Habits (check all the apply)

☐ Thumb/Finger Sucking ☐ Used Pacifier (If Yes) up to what age_______ ☐ Clench/Grind Teeth ☐ TMJ/TMD Pain

☐ Suck/Bite Lips ☐ Breast Fed (If Yes) until what age? _______ ☐ Speech Problems ☐ Tongue Thrust

☐ Bite/Chew Nails ☐ Bottle Fed (If Yes) until what age? _______ ☐ Mouth Breather ☐ Tongue/Cheek Biting

What is your child's Oral Hygiene Routine (check all that apply)

☐ Fluoride Toothpaste ☐ Non-Fluoridated Toothpaste ☐ Brushing by Child_______/day ☐ Dental Floss_______/week

☐ Fluoride Mouthwash ☐ Consume Fluoridated Water ☐ Brushing by Parent______/day

MEDICAL HISTORY

Child's Physician ______________________ Phone ( )__________ Date of Last Visit__________

Address ______________________

Is your child currently under the care of a physician? ☐ Yes ☐ No
(If Yes) Please explain ______________________

Does your child have social/personality/temperament concerns that we should be aware of ? ______________

Describe your child's physical health ☐ Good ☐ Fair ☐ Poor Immunizations Current? ☐ Yes ☐ No

Please list all medications and dosages that your child is currently taking______________________

Anything you would like to discuss with the Doctor in Private? ☐ Yes ☐ No

Has your child been diagnosed and/or treated for any of the following? (check all that apply)

☐ Abnormal Bleeding (Hemophilia) ☐ Eating Disorder ☐ Stomach/GI Disorders

☐ ADD/ADHD ☐ Epilepsy/Seizures/Convulsions ☐ Vision Problems

☐ NO CONDITIONS/HEALTHY

☐ Anemia/Blood Disorder ☐ Hearing Impaired

Allergies

☐ Asthma/Reactive Airway Disease ☐ Heart Murmur/Heart Defect/Heart Surgery ☐ Medication______________

☐ Autism Spectrum ☐ Immune Disorder/HIV/AIDS ☐ Food______________

☐ Cancer/Tumor/Leukemia ☐ Kidney Problems ☐ Latex ☐ Seasonal

☐ Congenital Birth Defects ☐ Premature/Low Birth Weight ☐ NONE

☐ Diabetes ☐ Speech Disorder

Financial Responsibility

I assume financial responsibility for all dental treatment and medications provided for my child, and understand that payment is expected on the date services are provided. I request and authorize my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I therefore am ultimately responsible for payment of services rendered on my behalf or my dependents.

Signature Date

Authorization and Release

To the best of my knowledge the information I have given on this form is correct, and I understand that providing and 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 exam rendered to my child during the period of such dental care to third party payers and/or their health practitioners.

I have received a copy of this office's Notice of Privacy Practices. I consent to their use and disclosure of my children(s) Protected Health Information to carry out treatment, payment activities and health care operations.

Signature Date

Appointment Policy

We greatly appreciate your efforts in honoring scheduled appointments and wish to provide all of our patients with the highest quality dental care in the most reasonable time possible. Please notify us 24 hours prior to your scheduled appointment if you will be unable to make it. If a patient fails or cancels two (2) scheduled appointments without 24 hours advanced notice, we will institute a broken appointment fee of $55. The fee must be settled prior to scheduling any future appointments.

Initial:___________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND DENTAL MATERIALS FACT SHEET

____

Signature Date

Dentist Signature Date