Cima Mazar-Atabaki
Board Certified Pediatric Dentist

24541 Pacific Park Drive Suite 104
Aliso Viejo, CA 92656
(949) 362-9860

Health History Update

Patient(s) Name_____

MEDICAL HISTORY UPDATE

Has there been any change in your child's medical history? ☐ YES ☐ NO
(If Yes) Please explain_____

Is your child currently taking any medication? ☐ YES ☐ NO
(If Yes) Please list_____

Does your child have any new allergies to medications? ☐ YES ☐ NO
(If Yes) Please list_____

DENTAL HISTORY UPDATE

Has there been any change in your child's dental history? ☐ YES ☐ NO
(If Yes) Please explain_____

Has there been any injury to the teeth, mouth, head or neck? ☐ YES ☐ NO
(If Yes) Please explain_____

Has your child been seen by an orthodontist? ☐ YES ☐ NO
(If Yes) Practitioner Name_____

Please state any problems you wish to bring to the doctor's attention_____

FAMILY UPDATE RECORD

What is your relationship to the patient? ☐ Biological ☐ Adopted/Foster ☐ Nanny ☐ Other

Is there a change in dental insurance? ☐ YES ☐ NO
(If Yes) New Insurance Carrier_____

Subscriber_____ Employer_____

ID/SS#_____ Date of Birth_____

Is there a change in your contact information? ☐ YES ☐ NO

(If Yes) Address_____ City_____ Zip_____

Mom's Cell#_____ Dad's Cell#_____ Email_____

I assume financial responsibility for all dental treatment 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.

Parent's Signature_____ Date_____

Dentist Signature_____ Date_____