Precious Pearls
PEDIATRIC DENTISTRY
Nadia Majeed, D.D.S.

Date: _____

Patient

Name: _____
Last First MI

Child's Nickname: _____ Child's DOB: ____/____/_____

Sex: [ ] Female [ ] Male Home Phone Number: (_____)_____ -_____

Home Address: _____
City State Zip Code

Parent One-Information

Name: _____
DOB: ____/____/_____
Employer: _____
Cell #: (_____)_____ -_____
Email: _____
Social Security #_____

Parent Two-Information

Name: _____
DOB: ___/____/_____
Employer: _____
Cell #: (_____)_____ -_____
Email: _____
Social Security # _____

Best Number to Reach: [ ] Home [ ] Cell [ ] Work
Best time to call: [ ] Morning [ ] Early afternoon [ ] Late afternoon

Dental Insurance

Please Circle Insurance Subscriber: Parent 1 / Parent 2
Insurance Carrier name: _____ Plan I.D. Number: _____
Group Number: _____ Phone number on card: _____

Assignment and Release

I certify that I, and/or my dependent(s), have insurance coverage with _____
And assign directly to Dr. Nadia Majeed D.D.S, all insurance benefits, if any, otherwise payable for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named dentist may use my health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____

Print Name of Patient Signature of Parent or Guardian

Emergency Contact

Name: _____Relationship: _____
Cell Number: _____ Home Number: _____

Your child's dental history

Is this your child's first visit to the dentist? [ ] Yes [ ] No
If not, how long has it been since your last visit?_____
Was the child's past visit(s) positive? [ ] Yes [ ] No
If not, please explain_____
Were there any X-rays Previously taken? [ ] Yes [ ] No **If Yes**: Date_____
Name of previous dentist and Location_____
Have there been any injuries to the face, teeth, or mouth? [ ] Yes [ ] No
If yes, please explain_____
Reason for today's visit? _____

Does your child have any of the following habits?

Thumb/Finger sucking [ ] Yes [ ] No Nail Biting [ ] Yes [ ] No
Nursing Bottle habits [ ] Yes [ ] No Grinding [ ] Yes [ ] No

Has your child ever had a serious or difficult problem associated with previous dental work?

_____

Is your child's water fluoridated? [ ] Yes [ ] No Is your child taking fluoride supplements? [ ] Yes [ ] No
Does your child drink bottled water? [ ] Yes [ ] No Does your child brush his/her teeth daily? [ ] Yes [ ] No
Floss his/ her teeth daily? [ ] Yes [ ] No Does your child have pain in his/her teeth today? [ ] Yes [ ] No

Has your child ever had any pain or tenderness in his/her jaw (TMJ/TMD)? [ ] Yes [ ] No

Is there any information you could share with us that might make your child feel more Comfortable during his/her first visit (hobbies, interests, etc)?

_____
_____

Your child's health history

Has your child had any of the following conditions (Please check box If so)?

[ ] ADD/ ADHD
[ ] Handicaps/ disabilities
[ ] Any hospital stays/Operations
[ ] Diabetes
[ ] Cancer/ Tumors
[ ] Heart Murmur
[ ] Rheumatic/ Scarlet Fever
[ ] Speech problems/ impairments
[ ] Sensory issues
[ ] Allergies to any drugs/ meds
[ ] Glandular/ Hormone Disease
[ ] Asthma/ Reactive Airway Disease
[ ] Exposure to HIV+/ AIDS
[ ] Kidney/ Liver Condition
[ ] Mental/Nervous Disorder
[ ] Congenital Birth Defects
[ ] Abnormal bleeding/ Hemophilia
[ ] Hearing/ Sight Impairment
[ ] Eating disorder/stomach problems
[ ] Hepatitis
[ ] Abnormal heart condition
[ ] Convulsions/ Epilepsy
[ ] Allergies to Latex Products

Please explain or list any other serious medical conditions your child has had _____
_____

Please list all medications your child is currently taking _____
_____

Please list ANY allergies your child may have (including foods)
_____
_____

Are your child's vaccinations up do date? [ ] Yes [ ] No (Please explain) _____
_____

Child's Physician_____ Date of last well visit_____

Location _____ Phone # ( )_____

Is your child currently under the care of a physician? Y / N
If yes, for what?_____

I understand that the information I have given is correct to the best of my knowledge that it will Held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status.

As the parent/guardian of _____, I authorize the dental Staff to perform the necessary dental services my child may need.

I also acknowledge that I am responsible for all the charges incurred in the rendering of dental Services at the time of treatment.

Signature_____ Date_____ Relation to patient_____

NO TREATMENT, ANESTHESIA OR X-RAYS WILL BE PERFORMED WITHOUT YOUR PRIOR KNOWLEDGE

Whom May We thank for referring you? _____

We understand that unplanned issues can come up and you may need to cancel an appointment. If that happens, we respectfully ask for scheduled appointments to be cancelled at least 48 hours in advance. There will be a fee of $50.00 assessed if we do not receive a call to cancel an appointment. Thank you