



# 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

## Parent Two-Information

Name: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Employer: \_\_\_\_\_

Employer: \_\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Email: \_\_\_\_\_

Email: \_\_\_\_\_

## Dental Insurance

Please Circle Insurance Subscriber: Parent 1 / Parent 2

Insurance Carrier name: \_\_\_\_\_ Plan I.D. Number: \_\_\_\_\_

## 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

Sensory issues

Abnormal bleeding/ Hemophilia

Handicaps/ disabilities

Allergies to any drugs/ meds

Hearing/ Sight Impairment

Any hospital stays/Operations

Glandular/ Hormone Disease

Eating disorder/stomach problems

Diabetes

Asthma/ Reactive Airway Disease

Hepatitis

Cancer/ Tumors

Exposure to HIV+/ AIDS

Abnormal heart condition

Heart Murmur

Kidney/ Liver Condition

Convulsions/ Epilepsy

Rheumatic/ Scarlet Fever

Mental/Nervous Disorder

Allergies to Latex Products

Speech problems/ impairments

Congenital Birth Defects

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

\_\_\_\_\_

Please list all medications your child is currently taking \_\_\_\_\_

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

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Are your child's vaccinations up do date?  Yes  No (Please explain) \_\_\_\_\_

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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*