SAN RAMON
CHILDREN'S DENTISTRY
AND ORTHODONTICS

JOANNE RAHMAN, DDS, MS

Date: _____

Patient Information

Child's Full Name_____ Age _____ Sex (M) (F)

Nickname (if any) _____Birthdate _____

Whom may we thank for referring you _____

General Information

Father/Stepfather/Partner/Legal Guardian Information:

Name:_____ SSN: _____ Birthdate:_____

Home Address _____

Home Phone: _____ Cell Phone: _____

Employer:_____

Business Address: _____ Work Phone: _____

Occupation: _____

E-mail: _____

Is it okay to contact this parent on your cellular number? Yes No

Is it okay to contact this parent via e-mail? Yes No

Mother/Stepmother/Partner/Legal Guardian Information:

Name:_____ SSN: _____ Birthdate:_____

Home Address _____

Home Phone: _____ Cell Phone: _____

Employer:_____

Business Address: _____ Work Phone: _____

Occupation: _____

E-mail: _____

Is it okay to contact this parent on your cellular number? Yes No

Is it okay to contact this parent via e-mail? Yes No

Parent(s) are: Married Divorced Single Widowed Partners Child lives with: _____

Person Financially responsible _____

Emergency Contact _____ Phone _____

SIGNATURE _____ Relationship _____

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Health History

Patient Name: _____ Date of Birth: _____

Social History

What is your child most interested in?_____
Names of brothers/sister_____ Is your child adopted? (Y) (N)
Name of Pets_____
Reason for today's visit _____
Child's school_____

Medical History

Child's pediatrician: _____Telephone #_____

Congenital Heart Problems / Murmurs / Rheumatic Fever	(Y)	(N)	Bone Disorder	(Y)	(N)
Growth & Development (learning, behavioral)	(Y)	(N)	Cancer/Malignancy	(Y)	(N)
Down's Syndrome	(Y)	(N)	Chemo/Radiation Therapy	(Y)	(N)
Autism	(Y)	(N)	Cystic Fibrosis	(Y)	(N)
Learning disabilities	(Y)	(N)	Allergies (if Yes, see below)	(Y)	(N)
Respiratory System / Pneumonia / Asthma	(Y)	(N)	Allergies to Medication	(Y)	(N)
Tuberculosis	(Y)	(N)	Endocrine / Diabetes	(Y)	(N)
Anemia	(Y)	(N)	Extremities/Arthritis/Joint problems	(Y)	(N)
Blood Disorders / Bruising	(Y)	(N)	ADHD/ADD	(Y)	(N)
Skin Problems / Cold Sores / Canker Sores	(Y)	(N)	Central Nervous System/Epilepsy/Seizure	(Y)	(N)
Hepatitis	(Y)	(N)	Bladder problems	(Y)	(N)
Brain Injury	(Y)	(N)	Cerebral Palsy	(Y)	(N)
Earaches/Infections	(Y)	(N)	Emotional/School Problems/Depression/Anxiety	(Y)	(N)
Hearing Impaired	(Y)	(N)	GI – stomach, intestinal, liver, jaundice	(Y)	(N)
Hospitalization	(Y)	(N)	Eating Disorder	(Y)	(N)

Has your child had any unfavorable reactions to drugs, antibiotics, or anesthetics? (Y) (N)

If yes, please list _____

Is your child currently taking any medications? (Y) (N) What kind? _____

Is your child protected by immunizations? (Y) (N) _____

Is your child taking any supplemental fluoride? (Y) (N) If yes, how? _____

Does your child have an allergic reaction to: (Please check all that apply) ____Medications ____Latex/Rubber ____Pollen/Dust ____Anesthetic ____ Animals(Dogs/Cats) ____Acrylic ____Dyes/Coloring ____Other Foods . If so, please list: _____

Dental History

Is this your child's dental first visit? (Y)(N) If no, previous dentist? _____Phone _____

Date of last visit _____How was his/her experience? _____ Were X-rays taken? (Y) (N)

Has your child had any injuries to teeth, mouth or head? (Y)(N) Please describe: _____

Does your child have any of the following habits? (past or present)? Please circle: Thumb/finger-sucking Pacifier

Nail-biting Lip-sucking Mouth-breathing Teeth-Grinding Snoring Bottle-feeding

Does your child currently use a bottle? (Y) (N) If yes, how often during the day? _____

Is the bottle used at night? (Y) (N) What do you put in the bottle? _____ Does your child currently nurse? (Y) (N)

How often does your child brush his/her teeth per day? _____ Do you help? (Y) (N)

How often does your child floss? _____ Do you floss your child's teeth? (Y) (N)

The permission of parent or guardian is necessary for dental treatment of a minor. I understand that the information I have given is correct to the best of my knowledge and it is my responsibility to inform the office of any changes in my child's health status. I authorize the dental staff to perform any necessary dental services my child may need. I understand that by signing this form I am accepting all responsibility for full payment of services rendered regardless of insurance coverage. I further understand that all payments are due and payable on the day services are rendered.

Parent/Guardian Signature: _____ Date_____

Doctor's Signature: _____ Date_____

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Insurance Information

Primary Insurance Company _____Phone Number _____

Subscriber _____ Birthdate _____ Group Number _____

Secondary Insurance Company _____Phone Number _____

Subscriber _____ Birthdate _____Group Number _____

As a courtesy to our patients, we will file your insurance claim with the insurance company listed above for treatments your child receives. However, in the event the insurance company, for any reason, does not pay, the balance will become your responsibility, and will be billed directly to you. You understand that this contract is with San Ramon Children's Dentistry and Orthodontics and yourself, and you are responsible for all charges on the account.

SIGNATURE OF RESPONSIBLE PARTY _____

Relationship _____ Date _____