Dentistry For Children
Amna Shebani, DDS

Child's First Name: _____ Middle Name: _____ Last Name: _____

Preferred name: _____Date of Birth: (mm/dd/yyyy) _____ Age: _____

Has your child ever been examined by another dentist? If so, where?	Y N	
Any unhappy dental experiences? If yes, please explain.	Y N	
Any injuries to mouth, teeth or head? If yes, please explain.	Y N	
Any mouth habits – thumb sucking, nail biting, mouth breathing, pacifier, nursing bottle habits, etc.? Please explain.	Y N	
Any unusual speech habits?	Y N	
Any missing or extra teeth?	Y N	
Have any teeth been replaced?	Y N	
Is your child wearing orthodontic appliances or braces? Please specify.	Y N	
Has your child previously worn orthodontic appliances or braces?	Y N	
Has your child ever had any unfavorable reactions to anesthetic?	Y N	
What is your child's attitude towards dentistry?		Normal Shy Apprehensive Frightened
Do you desire complete dental services for your child?	Y N	
Does your child brush their teeth daily?	Y N	
Do you assist your child with tooth brushing?	Y N	
Is an additional Fluoride supplement taken?	Y N	

Child's Physician: _____ Clinic Name: _____

Phone: _____ Date of Last Physical Exam: (mm/dd/yyyy) _____ Results: _____

Is your child currently under the care of a physician? If yes, please explain.	Y N	
Is your child receiving any medications or drugs? If yes, please list.	Y N	What?
Is there any excessive bleeding when cut?	Y N	
Has your child ever been hospitalized? If yes, please explain.	Y N	
Has your child ever had surgery? If yes, please explain.	Y N	
Is there any allergy to penicillin or other drugs? If yes, please list.	Y N	Which?
Are there other allergies: food, pollen, animals, dust, etc.?If yes, please list.	Y N	
Does your child have physical coordination problems? If yes, please explain.	Y N	
Does your child have any emotional problems? If yes, please explain.	Y N	
Are your child's vaccinations up to date?	Y N	
Has your child ever had a blood transfusion?	Y N	
Is your child adopted?	Y N	Does he/she know? Y N

Has your child had any history or difficulty with any of the following?

ADD/ADHD		Fever Blisters		Hearing Problems		HIV/AIDS		Psychiatric Care		Mental Retardation		Cancer	
Anemia		Growth Disorder		Heart Problems		Cortisone		Rheumatic Fever		Artificial Bone		Tourette Syndrome	
Drug/Alcohol use		Tuberculosis		Hemophilia		Handicapped		Sinus Problems		Asthma		Etc.	
Epilepsy		Cerebral Palsy		Hepatitis		Mitral Valve		Thyroid		Bulimia			

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed:

_____

_____

_____

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I CERTIFY THAT I AM THE DULY AUTHORIZED AGENT OF THE PATIENT AND THAT I HAVE READ AND UNDERSTAND THE ABOVE QUESTIONS. I WILL NOT HOLD DR. AMNA SHEBANI OR HER ASSOCIATES, OR ANY MEMBER OF HER STAFF, RESPONSIBLE FOR ANY ERRORS OR OMMISIONS THAT I MAY HAVE MADE IN COMPLETION OF THIS FORM.

Signature: _____ Date: _____ Relationship to Child: _____

MORE ON BACK

Patient Information

Patient(s) Address:	City:	State:	Zip code:

PARENT INFORMATION

Full Name of Parent #1: Date of Birth:	Full Name of Parent #2: Date of Birth:
Parent's Address:_____ City: _____ State: _____ Zip: _____	Parent's Address:_____ City: _____ State: _____ Zip: _____
Home Phone:	Home Phone:
Cell Phone:	Cell Phone:
Work Phone:	Work Phone:
Email Address:	Email Address:

INSURANCE

Occupation of parent #1:	Occupation of parent #2:
Employer:	Employer:
Dental Insurance Company:	Dental Insurance Company:
Social Security Number:	Social Security Number:
Group Number:	Group Number:
ID Number:	ID Number:

EMERGENCY CONTACT INFORMATION

Do both parents and child live together? Y N
If parents cannot be reached, who would you like us to contact? (family/friends/etc.) Name: _____ Relationship to Child:_____ Home Number: _____ Cell Number: _____
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Has any member of your family been a patient in this office? Y N
Name of family members: _____

CONSENT AND ASSIGNMENT FOR THE TREATMENT OF A MINOR
The undersigned hereby authorized Dr. Amna Shebani and associates (Dentistry for Children) to perform the examination and , after explanation, the necessary dental services and the methods she deems appropriate in her professional judgement for the care of the above names child. This authorization includes the release of my child's medical records if deemed necessary for proper care of my child. I further authorize that my insurance benefits be paid directly to the dentist and I remain in full force and effect until cancelled by either party.

Signature: _____ Date: _____ Relationship to Child: _____