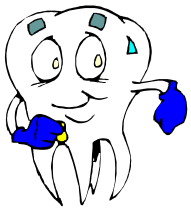
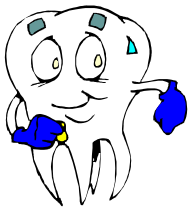
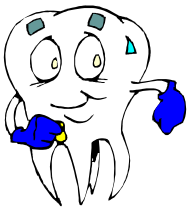

Welcome to Dr. Atashbar's Cosmetic & Family Dental Office!!!

We strive to make each of your child's visits pleasant and comfortable.
Our goal is to teach your child oral habits, which will help, keep their smile beautiful for their lifetime.

Your child

Child's name _____
Nickname _____ Sex _____
Birthdate _____
Social Security No. _____
School _____Grade_____
Child's home address _____
_____
City, State, Zip _____
Home Phone _____

□Mother □Stepmother □Guardian

Name _____
Birthdate_____
e-mail _____
Home Phone _____
Work Phone _____
Social Security No. _____
Employer _____
Occupation _____

□Father □Stepfather □Guardian

Name _____
Birthdate_____
e-mail _____
Home Phone _____
Work Phone _____
Social Security No. _____
Employer _____
Occupation _____

Parent's Marital Status

□Single □Married □Divorced
□Widow □Separated

Who is responsible for making appointments?

Name _____
Home Phone _____
Work Phone _____
Best time to call (time) _____
(days) _____

Who is responsible for making payments?

Name _____
Relationship _____
Address _____
_____
Social Security No. _____

Primary Dental Insurance

Insured's Name _____
Relationship _____
Birthdate _____
Soc.Sec.No. _____
Employer _____
Occupation_____
Insurance Company _____

Additional Insurance

Name Insured's _____
Relationship _____
Birthdate _____
Soc.Sec.No. _____
Employer _____
Occupation_____
Insurance Company _____

Over please →

Health History

Your child's overall health as well as any medications, which your child takes, could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Health History

Has your child had any difficulty with previous visits?
Comments: _____
Has your child ever had any of the following?

Asthma	□yes	□no
Cancer/Hepatitis	□yes	□no
HIV/AIDS	□yes	□no
Hemophilia	□yes	□no
Hepatitis (A,B,C,D,E)	□yes	□no
Diabetes	□yes	□no
Allergies	□yes	□no
Rheumatic Fever	□yes	□no
Congenital Heart Defect	□yes	□no
Convulsions/Epilepsy	□yes	□no
Tuberculosis	□yes	□no
Abnormal bleeding	□yes	□no
Heart Murmur	□yes	□no

Please list any/all medical problems that your child has, that are not listed above:

_____

Child's Habits

How often does your child brush? _____
How often does your child floss? _____
Date of last dental visit _____
Previous Dentist _____
Child's Physician _____
Phone Number _____
Is your child's water fluoridated? □yes □no
Is your child taking fluoride supplements? □yes □no
Does your child:

Suck thumb/finger	□yes □no
Suck/bite lips	□yes □no
Bite/chew nails	□yes □no
Chew hard objects (Pencils, etc.)	□yes □no
Grind teeth	□yes □no
Clench jaws	□yes □no

Does your child have to be pre-medicated with antibiotics prior to dental appointments? □ yes □ no
If Yes, please explain _____

Please list any/all medications your child is presently taking. _____

Patient Treatment Consent

I authorize the Dentist or designated staff treating my child to perform such diagnostic aids deemed appropriate to make a thorough diagnosis of my child needs. Upon such diagnosis, I authorized the Dentist to perform all recommended treatment and therapeutic procedures to include administering medications as prescribed by the Dentist and mutually agreed upon by me.
I assign all dental insurance benefits to which my child is entitled to the extent permitted under my dental insurance policy(s) to the Dentist. This form also authorized this Practice to submit insurance claim forms and receive payment directly from the insurance carrier with the notation "**SIGNATURE ON FILE**". I authorized the Dentist to release treatment records/x-rays or any other information deemed pertinent to the insurance carrier as necessary and/or requested.
I agree to be responsible for payment of all services rendered on my dependent. I agree that any unpaid claims the carrier does not pay or any balance that extends beyond 45 days from the date of treatment might be assessed to a service charge and/or turned over to a collection agency. I am aware that if the account is turned over to a collection agency, I will be responsible to pay 25% collection agency fees and/or $50.00 court costs and attorney fees.

I have read the above conditions of treatment and payment and agree to their content.

_____ (SEAL) _____
Signature of parent/guardian **Date**

The interested parties may revoke this authorization in writing only.
Please note once records are established there is a $35.00 charge for duplication of records including x-rays.
A $45.00 Broken appointment fee will be applied for missed or canceled appointments without 48 hours notice.