American Dental Solutions

Mehjabeen Zahirsha, DDS (Dr.Zee)

1. ABOUT YOUR CHILD

Date: ____________________

Child's Name: ______________________________________
Last First Middle

Nick Name: ____________ ☐ Boy ☐ Girl

Child's Birth date: ____________ Age: ____ SSN# ______________

Child's Mailing Address: ______________________________

____

Child's Home Phone: ______________ Parent Cell: ______________

Parent's Work Phone: __________________

Parent E-mail address: ______________________________

Parent Employer: __________________ How long? ______

Parent's Employer's Address:

____

____

Occupation: ______________________

Status: ☐ Minor ☐ Single ☐ Mrried ☐ Divorced
☐ Separated ☐ Widowed

Spouse's name: __________________________

Do you have any other Children? ☐ Yes ☐ No How many? ____

2. IN EVENT OF CHILD"S EMERGENCY

Whom should we contact? ______________________

Relation: ______________________

Home Phone: ___________ Work Phone: ___________

Cell Phone: ______________________

Who is your Medical/family Doctor? ____________________

Medical/Family Doctor phone #: _______________

3. INSURANCE INFORMATION

Primary Insurance: ______________________

Phone: ______________________

Insurance ID # ______________________

Group ID# ______________________

Insured's Name: ______________________

Insured's Employer Name: ______________________

Secondary Insurance: ______________________

Insurance ID # ______________________

Group ID# ______________________

Insured's Name: ______________________

4. ACCOUNT INFORMATION

Person Ultimately responsible for payment

Name: ______________________

Relation to Child: ______________________

Billing Address: ______________________

____

SSN #: ______________________

Drivers License # : ______________________

Work Phone #: ______________________

_______ I hereby authorize assignment of my
initial
insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. (if offered at this office)

5.REFERRALS

How did you hear about us?

☐ Phone Book ☐ Direct mail

☐ New paper ☐ Internet

☐ Others ____________

☐ Referred by: ____________________

Please fill out all the information on both sides

American Dental

6. CHILD's DENTAL INFORMATION

Reason for today's visit: □ Exam □ Emergency □ Consultation

Is Child in pain? : □ Yes □ No How Long? ____________

Please indicate ■ any of the following problems:

□ Discomfort, clicking or popping in jaw □ lost/Broken Filling(s) □ Stained teeth □ Red, swollen or bleeding gums □ Teeth grinding □ Locking Jaw □ Sensitive tooth, teeth or gums □ ringing in Ears □ Bad breath □ Blisters/Sores in or around the mouth □ Broken/Chipped tooth □ Others ________________

Does child require pre-medication? □ Yes □ No □ Don't know

Previous Dentist : Dr ________________________ Phone No: ________________________

Last Dental Exam: _____/_____/_____ Last Dental X-rays: _______/_______/_______

How many times a day childbrush? _____ How many times week child floss?: _____

What type of tooth brush bristles child use? □ Soft □ Medium □ Hard Does child use Sonic brushes? □ Yes □ No □

How would you rate your child's smile ? 1 2 3 4 5 6 7 8 9 10

(Worst) 1 (Best) 10

7. CHILD'S MEDICAL INFORMATION

What medications are you taking? □ Nerve pills □ Pain Killers □ Asprin □ Muscle relaxes □ Stimulants □ Blood thinners □ Tranquilizers □ Insulin □ Ritalin □ Other(s), please list ________________________________

Does child have or ever had any of the following diseases, medical conditions or procedures?

Y N	Heart Attack / Stroke	Y N	Thyroid Problems	Y N	Cancer/Tumors	Y N	Cosmetic Surgery
Y N	Heart Surg/Pace maker	Y N	Kidney Problems	Y N	Shingles	Y N	Xray or Cobalt Treatment
Y N	Heart Murmur	Y N	Liver Problems	Y N	Hepatitis	Y N	Chemotherapy
Y N	Rheumatic Fever	Y N	Respiratory Problems	Y N	HIV+/AIDS/ARC	Y N	Asthma
Y N	Mitral valve prolpse	Y N	Sinus problems	Y N	Arthritis/ Rheumatism	Y N	Difficulty Breathing
Y N	Artificial Valves	Y N	Stomach problem /Ulcers	Y N	Artificial Bones/Joints	Y N	Diabetes/Hypoglycemia
Y N	Heart Disease	Y N	Psychiatric problem	Y N	Emphysema	Y N	Leukemia
Y N	Congenital Heart Defect	Y N	Venereal Disease	Y N	Fainting/Seizures/Epilepsy	Y N	Anemia
Y N	Chest Pains	Y N	Alcohol/Drug Abuse	Y N	Severe/Freqt. Headache	Y N	High/Low Blood pressure
Y N	Scarlet Fever	Y N	Tuberculosis TB	Y N	Frequent Neck pain	Y N	Bleeding problem
Y N	Nervousness	Y N	Jaw Problem TMJ/TMD	Y N	Back Problems	Y N	Glaucoma

Please list any other surgeries or medical conditions you have or ever had: ________________________________

Does child allergic to any of the following? □ Latex □ Penicillin / Amoxicillin □ Tetracycline □ Asprin □ Dental Anesthetics □ Foods: ________________________ □ Others: ________________

Has this child eve taken the drug Ritalin? □ No □ Yes How long? ______________ Child's Blood Type: __________

Please rate your general health from scale 1- 10 (10 excellent, 1 poor) __________ Does child wear contact lenses? □ Yes □ No □

Does this child do any of the following? □ thumb/Finger Sucking □ Tongue Thrusting/Sucking □ Heavy Snoring □ Mouth Breathing □ Lip Sucking/Biting

□ We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.

□ Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with business manager. If account is not paid within 60 days of the date of service and no financial arrangement have been made, you will be responsible for legal fees, collection agency fees, interest charges 18% per annum and any other expenses incurred in collecting your account.

□I I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.

□ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature: ________________________________ Date: _____/_____/_____

□ Parent or Guardian □ other