



Healthy Teeth & Smiles Start Here!

J. SHAHANGIAN, DDS, MS (858) 800-2000

Please complete both pages for each child and email to staff@scripps PediatricDentistry.com

Child's Name _____ Preferred Name _____

Sex: M F Birth Date: _____ Age _____ Previous Dentist _____ Date of last visit _____

Is your child adopted? _____ Who has legal guardianship of your child? _____

Your child's attitude toward previous dental care? _____

Reason for this visit? _____ **How did you hear about our office?** _____

Names of siblings: Name _____ Age _____ Name _____ Age _____
 Name _____ Age _____ Name _____ Age _____

Is your child engaged/use social media? Yes No I don't know

Child's Cell _____ Child's Email _____

MEDICAL INFORMATION

Dr.'s Name _____ Address _____ Phone _____

Is your child taking any medication? _____ What kind? _____

Reason _____

Has your child ever been hospitalized? _____ When? _____ Reason _____

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

YES	NO	YES	NO	YES	NO			
<input type="checkbox"/>	<input type="checkbox"/>	Seasonal Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/Breathing Problems	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	<input type="checkbox"/>	Autism	<input type="checkbox"/>	<input type="checkbox"/>	Anemia/Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Bones
<input type="checkbox"/>	<input type="checkbox"/>	Cancer/Tumors	<input type="checkbox"/>	<input type="checkbox"/>	Cerebral Palsy	<input type="checkbox"/>	<input type="checkbox"/>	Cleft Lip/Palate
<input type="checkbox"/>	<input type="checkbox"/>	Developmental	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Eyes, Ears, Nose, Throat
<input type="checkbox"/>	<input type="checkbox"/>	Hearing	<input type="checkbox"/>	<input type="checkbox"/>	Heart	<input type="checkbox"/>	<input type="checkbox"/>	Kidney
<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Immune Deficiency	<input type="checkbox"/>	<input type="checkbox"/>	Liver
<input type="checkbox"/>	<input type="checkbox"/>	General Anesthesia/Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	Stomach/Intestinal
<input type="checkbox"/>	<input type="checkbox"/>	Syndromes	<input type="checkbox"/>	<input type="checkbox"/>	Other _____			

Comments/Details _____

Does your child have any emotional or school problems? _____

Allergies to Food or Medications _____

DENTAL INFORMATION

Has your child ever had any injuries to his teeth, mouth or head? _____ When? _____ Details _____

Does your child brush regularly? _____ How often? _____

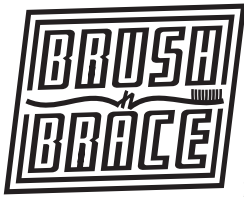
Does your child floss? _____ How often? _____

Has either parent or child been treated orthodontically? _____ Name of Orthodontist _____

How do you expect your child's reaction will be towards receiving dental care in our office? _____

Describe your child: Outgoing Shy Rebellious Anxious Other _____

How may we help to make dental visits a positive experience for your child? _____



Healthy Teeth & Smiles Start Here!
J. SHAHANGIAN, DDS, MS (858) 800-2000

Please complete both pages for each child and email to staff@scripps PediatricDentistry.com

RESPONSIBLE PARTY

First Name _____ Last Name _____ Middle Initial _____
Address _____ City, State, Zip _____
Home Phone _____ Work Phone _____ Cell _____
Birth Date _____ Soc Sec _____ Employer _____
Email _____ (we do most of our communications via email and NEVER spam.)

Who can we thank for referring you to our practice? _____

MOTHER'S INFORMATION (if different from responsible party)

Name _____ Employer _____ Occupation _____
Address _____ Cell # _____ Date of Birth _____

FATHER'S INFORMATION (if different from responsible party)

Name _____ Employer _____ Occupation _____
Address _____ Cell # _____ Date of Birth _____

PRIMARY DENTAL INSURANCE

Policy Holder Name _____
Social Security# _____
Ins. Company Name _____
Policy/ Group Number _____
Ins. Address _____
Ins. Phone # _____

SECONDARY DENTAL INSURANCE (if any)

Policy Holder Name _____
Social Security# _____
Ins. Company Name _____
Policy/ Group Number _____
Ins. Address _____
Ins. Phone # _____

FINANCIAL POLICY

Your child's estimated share of cost is due and payable on the day the treatment is performed. Understand that dental insurance usually covers only part of the fees for services based on your specific dental benefit underwriting. We do our best to provide you with an estimate accordingly. Please understand that the contract for dental insurance is between you and your insurance company and not our practice. Any disputes of coverage need to be handled through the insurance company directly by you and you accept personal financial responsibility for services provided. Your signature here authorizes assignment of benefits to us so we can submit claims.

To avoid missed appointment charges we request that you inform us of cancellation notice 48 hours prior to the appointment, so that we can offer the appointment to another child. If you have 2 broken appointments, you will be automatically charged \$50.00 for your missed appointments. A broken appointment is considered a "no show" or cancelling an appointment the same day.

The signature of the responsible party / Legal Guardian below authorizes Dr. J Shahangian or qualified assignee to complete an oral evaluation including but not limited to examination, cleaning, fluoride and/or diagnostic X-rays as indicated to evaluate oral health.

SIGNATURE _____ RELATIONSHIP TO CHILD _____ DATE _____