KID'S CHOICE DENTAL
Dr. Susan Jarakian, D.D.S

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Family Information

PATIENT'S FULL NAME			DATE OF BIRTH
ADDRESS	CITY	ZIP CODE	HOME PHONE ( )
FATHER'S FULL NAME	ADDRESS (IF DIFFERENT FROM PATIENT'S)	FATHER'S HOME PHONE ( )	FATHER'S CELL PHONE ( )
FATHER'S EMPLOYER	BUSINESS ADDRESS	FATHER'S WORK PHONE ( )	FATHER'S OCCUPATION
FATHER'S E-MAIL ADDRESS	FATHER'S SOCIAL SECURITY #	FATHER'S DATE OF BIRTH	FATHER'S DRIVER LICENSE #
MOTHER'S FULL NAME	ADDRESS (IF DIFFERENT FROM PATIENT'S)	MOTHER'S HOME PHONE ( )	MOTHER'S CELL PHONE ( )
MOTHER'S EMPLOYER	BUSINESS ADDRESS	MOTHER'S WORK PHONE ( )	MOTHER'S OCCUPATION
MOTHER'S E-MAIL ADDRESS	MOTHER'S SOCIAL SECURITY #	MOTHER'S DATE OF BIRTH	MOTHER'S DRIVER LICENSE #
NAME & PHONE NUMBER OF CLOSE RELATIVE OR FRIEND		SIBLINGS NAME & AGE	
HAS ANY MEMBER OF YOUR FAMILY BEEN A PATIENT IN THIS OFFICE BEFORE? ☐ YES ☐ NO		IF YES, NAME(S)	

Authorization & Financial Responsibility

IS YOUR CHILD COVERED BY A DENTAL PLAN? ☐ YES ☐ NO IF YES, UNDER WHOSE PLAN IS THE CHILD'S COVERAGE? ☐ FATHER ☐ MOTHER

NAME OF PARENT INSURED (1)	NAME OF INSURANCE CARRIER	INSURANCE PHONE ( )	GROUP OR POLICY #
NAME OF PARENT INSURED (2)	NAME OF INSURANCE CARRIER	INSURANCE PHONE ( )	GROUP OR POLICY #

IS YOUR CHILD COVERED BY ANY ADDITIONAL DENTAL PLANS? ☐ YES ☐ NO IF YES, UNDER WHOSE PLAN IS THE CHILD'S COVERAGE? ☐ FATHER ☐ MOTHER

NAME OF PARENT INSURED (1)	NAME OF INSURANCE CARRIER	INSURANCE PHONE ( )	GROUP OR POLICY #
NAME OF PARENT INSURED (2)	NAME OF INSURANCE CARRIER	INSURANCE PHONE ( )	GROUP OR POLICY #

NAME OF INDIVIDUAL RESPONSIBLE FOR ACCOUNT

I hereby authorize Dr. Susan Jarakian, D.D.S. to perform any and all treatments for my above named child and consent to such methods, drugs, and agents as may be indicated in connection with his/her dental care. This consent shall remain in effect until cancelled.

PLEASE NOTE: Payment is expected for service rendered at the time of each visit. Financial arrangements may be made following the diagnosis. A monthly finance charge of 1 1/2% is added to all amounts after 90 days. This represents an annual percentage charge of 18%.

SIGNATURE OF PARENT OR LEGAL GUARDIAN _____ DATE _____

OFFICE USE ONLY

Reviewed By: Date: Entered By: Date: Rec#

CHILD'S FULL NAME FIRST	MIDDLE	LAST	(NICKNAME)	❑ MALE ❑ FEMALE

AGE	DATE OF BIRTH	PLACE OF BIRTH	SCHOOL	GRADE

REFERRED TO THIS OFFICE BY:	REASON FOR THIS VISIT

Medical History

NAME OF CHILD'S PHYSICIAN	CITY	PHONE ( )	DATE OF LAST VISIT (MO/YR)

Was your child born of a normal 9 months term pregnancy?	❑ YES ❑ NO	IF PREMATURE, HOW MANY MONTHS?
Is your child presently under the care of a physician?	❑ YES ❑ NO	IF YES, PLEASE EXPLAIN:
Has your child ever been hospitalized?	❑ YES ❑ NO	IF YES, PLEASE EXPLAIN:
Is your child taking any medications now?	❑ YES ❑ NO	IF YES, PLEASE EXPLAIN:
Is your child handicapped in any way?	❑ YES ❑ NO	IF YES, PLEASE EXPLAIN:
Is your child allergic to any medications, foods or latex?	❑ YES ❑ NO	IF YES, PLEASE EXPLAIN:

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING CONDITIONS?

❑ Heart Trouble or Murmur	❑ Cancer	❑ Cerebral Palsy
❑ Rheumatic Fever	❑ Hepatitis	❑ Mental Retardation
❑ Brain Injury	❑ Bleeding Problem	❑ Speech/Learning Disabilities
❑ Diabetes	❑ Anemia	❑ Eye Problems
❑ Asthma	❑ Blood Transfusion	❑ Skin Disorder
❑ Seizures	❑ Bladder/Kidney Disorder	❑ Emotional Disturbances
❑ Epilepsy	❑ Ear Infections	❑ HIV Positive/AIDS

(FOR ADOLESCENT FEMALE PATIENTS) DOES YOUR CHILD HAVE ANY OF THE FOLLOWING CONDITIONS?

❑ Pregnant (or might be) ❑ Taking Birth Control Pills ❑ Ever Taken Diet Pills/ Weight Loss Medications

Dental History

CHILD'S FIRST DENTAL VISIT	PREVIOUS DENTIST	CITY	DATE OF LAST VISIT

ANY UNFAVORABLE REACTIONS TO PREVIOUS MEDICAL OR DENTAL CARE? ❑ YES ❑ NO	IF YES, PLEASE EXPLAIN:
HOW DO YOU THINK YOUR CHILD WILL REACT TOWARD THE DENTIST?	NAME OF FAMILY DENTIST CITY
ANY INJURIES TO TEETH OR JAWS? (FALLS, BLOWS, CHIPS, ETC.) ❑ YES ❑ NO	IF YES, PLEASE EXPLAIN NATURE OF INJURY AND DATE

HOW OFTEN DOES YOUR CHILD BRUSH?	DOES YOUR CHILD RECEIVE: ❑ Fluoride In Vitamins ❑ Fluoride Tables/Drops ❑ Fluoridated Water ❑ None
IS BRUSHING ASSISTED BY AN ADULT? ❑ YES ❑ NO	
DO THE GUMS BLEED WHEN TEETH ARE BRUSHED? ❑ YES ❑ NO	HISTORY OF: ❑ Thumb Sucking ❑ Teeth Grinding ❑ Pacifier ❑ Lip Sucking ❑ Tongue Thrusting
IS DENTAL FLOSS USED? ❑ YES ❑ NO	

FOR PATIENTS UNDER 5 YEARS OLD: CHILD STILL USING A BOTTLE? ❑ YES ❑ NO

Any other medical conditions or anything else you would like to bring to the Dentist's attention?