

WELCOME

Discovery Children's Dentistry
Cyrus Sheikh, D.D.S., M.S.
6994 El Camino Real, Suite 101
Carlsbad, CA 92009
(760) 438-1279 fax (760) 438-8793



Health History Form

For your convenience... Print this form, complete all information, and bring it with you on your first visit to our office. The parent or Guardian who accompanies the child is responsible for payment at the time of service.

Who may we thank for referring you to our office? _____

1. Tell Us About Your Child

Child's Name _____
Last First MI

Nickname _____ Male Female

Siblings that we treat _____

Child's Birthdate ____/____/____ Child's Age _____

Child's Home # (_____) _____

SS# _____

Child's Home Address: _____

_____ APT. / CONDO #

City State Zip

2. Mother's Information

Name _____

Stepmother Guardian Birthdate ____/____/____

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

3. Father's Information

Name _____

Stepfather Guardian Birthdate ____/____/____

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

Marital Status

Single Married Separated
 Widowed Divorced

4. Who is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? Yes No

5. Person Responsible for Account

Name _____

Relationship _____

Billing Address _____

City State Zip

Home # (_____) _____

Work # (_____) _____

E-mail _____

6. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____/____/____

Social Security # _____

Policy Owner's Employer _____

7. Dental History

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain _____

Why did you bring the child to the dentist today? _____

Does the child have any of the following habits?

Y N Lip Sucking / Biting Y N Nail Biting

Y N Nursing Bottle Habits Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain _____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

8. Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding Y N Handicaps/Disabilities

Y N Allergies to any Drugs Y N Hearing Impairment

Y N Any Hospital Stays Y N Heart Murmur

Y N Any Operations Y N Hemophilia

Y N Asthma Y N Hepatitis

Y N Cancer Y N HIV + / AIDS

Y N Congenital Heart Disease Y N Kidney/Liver Conditions

Y N Convulsions/Epilepsy Y N Rheumatic/Scarlet Fever

Y N Pregnancy Y N Allergies to Latex Product

Please discuss any serious medical conditions the child has had

Please list all drugs the child is currently taking _____




Please list all drugs the child is allergic to _____

Child's Physician _____

Phone (_____) _____

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health...

 Good  Fair  Poor

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

9. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian _____

Date _____

Relationship to Patient _____

For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials _____ Date _____

Insurance Verification: Effective Date ____/____/____

Preventive _____% Deductible \$ _____

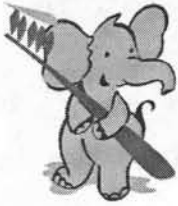
Basic _____% Maximum \$ _____

Major _____% Electronic Claims Yes No

Doctor's Comments _____

Does insurance cover sealants (1351)? Yes No

If yes, what do they fall under? _____



Discovery Children's Dentistry
Cyrous Sheikh, D.D.S., M.S.
6221 Metropolitan St., Suite 202
Carlsbad, CA 92009
(760) 438-1279 fax (760) 438-8793

CONSENT FORM

Date _____

Sex M F

Child's Name _____ Nickname (if any) _____

Parent's Name(s) _____

Address _____

Release *(Please initial next to each item)*

_____ I authorise the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.

_____ I authorise the dentist to perform radiographs (x-rays) as may be necessary for proper dental care.

_____ I authorise release of any information concerning my child's health care, advice and treatment provided for the purpose of evaluation and administering claims for insurance benefits.

_____ I authorise release of any information concerning my child's health care, advice and treatment to another dentist.

_____ I hereby authorise payment of insurance benefits directly to the dentist or dental group, otherwise payable to me.

_____ I understand that my dental care insurance carrier or payor of my dental benefits may pay less than the actual bill for services. I understand I am financially responsible for payment in full of all accounts. By signing this statement, I revoke all previous agreements to the contrary and agree to be responsible for payment of services not paid, in whole or in part by my dental care payor.

Acknowledgements

_____ I acknowledge receipt of the Dental Materials Fact Sheet.

_____ I acknowledge receipt of the HIPAA or Health Insurance Portability Accountability Act form.

Parent/Guardian's Signature: _____ Date _____

Relationship to Patient _____