Welcome to our Office

Dr. Berge Najarian DDS

PATIENT INFORMATION

Child's Name: ______________________ (Last / First / M) Nickname: ______________

Birthdate: __________ Age: ______ Sex: MALE / FEMALE SSN: __________ Phone # __________

Marital Status: SINGLE / MARRIED / DIVORCED / WIDOWED Email: ______________________

Address: ______________________ City/State: __________ ZIP: ________

School: ______________ Grade: ________ Hobbies/sports: ______________

WHO'S ACCOMPANYING YOUR CHILD TODAY?

His/Her Name: ______________________ (Last / First) Relation: ______________

Do you have legal custody? YES / NO How did you hear about us? ______________________

General Dentist: ______________ Last visit date: __________ Office # __________

MOTHER'S INFORMATION

Name: ______________________ Birthdate: __________ Phone # __________

Email: ______________________ SSN: __________ DL # __________

Employer: ______________ Work Phone # __________

FATHER'S INFORMATION

Name: ______________________ Birthdate: __________ Phone # __________

Email: ______________________ SSN: __________ DL # __________

Employer: ______________ Work Phone # __________

PERSON RESPONISBLE FOR ACCOUNT

Name: ______________________ Relation: __________ Phone # __________

Address: ______________________ City/State: __________ ZIP: ________

Email: ______________________ SSN: __________ DL # __________

Employer: ______________ Work Phone # __________

INSURANCE INFORMATION

Orthodontic Coverage: YES / NO Dental Coverage: YES / NO Insurance Co. Name: ______________

Insurance Co. Address: ______________________ Insurance Co. Phone # __________

Insured's Name: ______________________ Relation: __________ Birthdate:

Insured's ID # ______________________ Insured's Employer: ______________

SECONDARY INSURANCE INFORMATION

Orthodontic Coverage: YES / NO Dental Coverage: YES / NO Insurance Co. Name: ______________________

Insurance Co. Address: ______________________ Insurance Co. Phone # ______________________

Insured's Name: ______________________ Relation: ______________ Birthdate: ______________

Insured's ID # ______________________ Insured's Employer: ______________________

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

			List any serious medical conditions your child ever had:
Y / N Abnormal Bleeding	Y / N Asthma	Y / N Hemophilia	______________________
Y / N ADD/ADHD	Y / N Cancer/Chemotherapy	Y / N Hepatitis	______________________
Y / N Allergies to any Drugs	Y / N Congenital Heart Defect	Y / N HIV+/AIDS	______________________
Y / N Allergic to Latex/Metals	Y / N Epilepsy/Convulsions	Y / N Kidney/Liver Problems	______________________
Y / N Allergic to Plastic	Y / N Diabetes	Y / N Lupus	______________________
Y / N Any Hospital Stays	Y / N Handicaps/Disabilites	Y / N Rheumatic/Scarlet Fever	
Y / N Any Operations	Y / N Hearing Impairment	Y / N Tuberculosis (TB)	
Y / N Artificial Bones/Joints/Valves	Y / N Heart Murmur		

HAS YOUR CHILD EVER EXPERIENCED ANY OF THE FOLLOWING?

Y / N Clenching/Grinding Teeth	Y / N Mouth Breather	Y / N Nursing Bottle Habbits	Y / N Thumb/Finger Sucking
Y / N Lip Sucking/Biting	Y / N Nail Biting	Y / N Speech Problems	Y / N Tongue Thrust

Please list all drugs your child is currently taking: ______________________

Please list all durgs/things your child is allergic to: ______________________

What are the main concerns you'd like orthodontics to accomplish? ______________________

As your child ever been evaluated for orthodontic treatment? YES / NO

Has your child ever had an injury to their: FACE / MOUTH / TEETH / CHIN Adenoids or tonsils removed? YES / NO

Has your child ever had any pain/discomfort in his/her jaw joint (TMJ/TMD)? YES / NO

Any missing or extra permanent teeth? YES / NO List musical insturments played: ______________________

Has your child ever taken Phen-Fen? (aka Redux or Pamdimin) YES / NO If yes, when? ______________________

Does your child brush their teeth daily? YES / NO Floss their teeth daily? YES / NO

Child's Physician: ______________________ Phone # ______________ Last Visit: ______________

Currently under the care of a physician? YES / NO Is your child's current physical health: GOOD / FAIR / POOR

Has puberty begun? YES / NO Has menstruation begun? (Girls) YES / NO

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dental staff to perform any necessary dental servicesmy cihild may need.

____

Signature Date

I understand that this office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may, at the discretion of the office, use the services of one or more credit reporting services.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I hereby authorize payment of the group insurance benefits directly to this office. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

____

Signature Date

OFFICE USE ONLY! OFFICE USE ONLY! OFFICE USE ONLY!

I verbally reviewed the medical/dental information above with the patient named. Initial: ______________ Date: ______________

Notes: ____