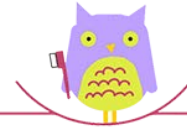


WELCOME KIDS!



TRIAD PEDIATRIC DENTISTRY
DENTISTRY WITH A MOTHER'S TOUCH

Child's Registration & History

Today's Date: _____

Child's Name: _____
First Middle Last

Date of Birth: _____ Nickname: _____

Male Female Hobbies _____

Home Address: _____
Street Address

City State Zip Code

Child's Home #: (____) _____ SS#: _____

School the child attends: _____ Grade _____

Who is accompanying the child today?

Name _____ Relation _____

Do you have legal custody of the child? . Yes . No

Whom may we thank for referring you?

Other siblings? _____

Prev. Dentist: _____

Last Visit Date: _____ Phone #: (____) _____

Person Responsible for the account: _____

Parent's Marital Status: Single Married

Partnered Widowed Divorced Separated

Father Step Father Guardian

Name: _____
First Middle Last

Date of Birth: _____ SSN: _____

Address (if different from child's) Hm # (____) _____

Work #: (____) _____ Cell #: (____) _____

Email: _____

Employer: _____ How Long? _____

Employer's Address: _____

Mother Step Mother Guardian

Name: _____
First Middle Last

Date of Birth: _____ SSN: _____

Address (if different from child's) Hm # (____) _____

Work #: (____) _____ Cell #: (____) _____

Email: _____

Employer: _____ How Long? _____

Employer's Address: _____

Dental Insurance Company: _____

Group #: _____ ID#: _____

Address for Dental Claims: _____
Street Address City State Zip Code

Child's name: _____ Date of Birth: _____ Date: _____

Medical and Dental History

Your child's overall health, as well as any medications that he/she takes, may have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

Medical History

Child's Physician: _____

Physician's Address: _____

Date of Last Physical: _____

Is your child up to date on vaccinations? _____

Has your child ever had any of the following?

Asthma yes . no

Cancer/Tumors yes . no

Hepatitis yes . no

HIV/Aids yes . no

Hemophilia yes . no

Diabetes yes . no

Kidney Problems yes . no

Liver/GI Problems yes . no

Endocrine Abnormalities yes . no

Allergies (seasonal) yes . no

Allergies (food,drug) yes . no

Explain _____

Hearing Problems yes . no

Eye Disorders yes . no

Breathing/Lung Problems yes . no

Blood Disorders yes . no

Adverse Drug Reaction yes . no

Rheumatic Fever yes . no

Congenital Heart Defect yes . no

Congenital Birth Defect yes . no

Mental/Physical yes . no

Development Delays yes . no

Behavioral/Learning Problems yes . no

Seizures/Epilepsy yes . no

Social Development Delays yes . no

Recurrent/Freq. Headaches yes . no

Tuberculosis yes . no

Frequent Infections yes . no

Significant Injuries yes . no

Explain _____

Hospitalizations yes . no

Explain _____

Abnormal Bleeding yes . no

History of Blood Transfusion yes . no

Date _____

Heart Ailments yes . no

Heart Murmur yes . no

Type _____

Premed Needed yes . no

Please explain any other medical problems
child has _____

_____.

Child's Medications

Please list your child's medications & dosages:

Dental History

What are your main concerns about your child's dental
no health? _____

How frequently are your child's teeth brushed? _____

How frequently are your child's teeth flossed? _____

Do you help your child with brushing/flossing?

yes . no

Date of last dental visit _____ xrays _____

Previous Dentist _____

How would you describe your last dental experience?

Does your child have a healthy diet? _____

Does your child's family have a history of dental decay or
gum disease? yes . no

Is your child's drinking water fluorinated? yes . no

Does your child take fluoride supplement? yes . no

If yes, dosage: _____

Does your child:

Suck thumb/finger/lips/pacifier? yes . no

Bite/chew nails or hard objects? yes . no

Grind teeth/clench jaws? yes . no

Use a bottle/sippy cup? yes . no

Breast feed/how long? _____ yes . no

Eat/drink after brushing? yes . no

Brush before bed? yes . no

Drink more than 1 glass of juice, tea, soda, or sports drink
per day? yes . no

Have a history of dental trauma? yes . no

Authorization & Release

To the best of my knowledge, the questions on this form
have been accurately answered. I understand that
providing incorrect information can be dangerous to my
child's health. It is my responsibility to inform the dental
office of any changes in my child's medical status. I
authorize the dentist to release any information
including the diagnosis and the records of any treatment
or examinations rendered to my child during the period
of such dental care to third party payers and/or health
that your practitioners. I also consent to any necessary
radiographs (x-rays) needed for proper diagnosis.

X _____

Signature of parent/guardian

date

Photograph/Video Consent Form

Name of Participant(s): _____ Date: _____

I hereby give my permission to **Triad Dentistry & Sona J Isharani, DDS** to use any photos/videos of the child(ren) listed above. The photos/videos will only be used for promotional purposes and for the presentation of pediatric patients to other parents who may be considering bringing their children to our practice. These photos/videos may be used on the practice's Facebook fan page, website, or printed materials. I may at any time withdraw my permission for photos or videos of my child(ren).

Signature: _____