ROYAL DENTAL
CHILD INFORMATION SHEET

Thank you for choosing our Dental office; we will do our best to make your appointments as pleasant and convenient as possible. It is our office policy to receive payment by cash, check or credit card at the time services are rendered. If you have any questions regarding your treatment, appointments, or fees, feel free to ask. Please answer the following questions as completely as possible.

Account #: ______________________ **Office #:** ______________________

PATIENT INFORMATION

Patient's Name:______________________ Social Security #: ______________________

Address:______________________ Birth Date: ________/________/________

City / State / Zip:______________________ Sex (check one): ______Male ______Female

PARENT / PRIMARY INSURED INFORMATION

Name:______________________ Relationship to patient:______________________

Address (if different than above):______________________ C/S/Z:______________________

Social Security #:______________________ Birth Date: ________/________/________

Employer:______________________ Home Phone:______________________

Insurance Company:______________________ Mobile Phone:______________________

Policy #:______________ Group #:______________ Work Phone:______________________

Member ID #:______________________ Email:______________________

PARENT / SPOUSE INFORMATION

Name:______________________ Relationship to patient:______________________

Address (if different than above):______________________ C/S/Z:______________________

Social Security #:______________________ Birth Date: ________/________/________

Employer:______________________ Home Phone:______________________

Insurance Company:______________________ Mobile Phone:______________________

Policy #:______________ Group #:______________ Work Phone:______________________

Member ID #:______________________ Email:______________________

Nearest relative not living with you:______________________ Relationship:______________________

Phone:______________ Address:______________________

Purpose of your visit:______________________

Names of family members who are patients:______________________

How did you hear about our office? ______________________

I hereby assign all dental and medical benefits to which I am entitled to Lalji Dental P.C. A photocopy of this assignment is to be considered valid as an original. I hereby authorize said assignee to release all information to secure payment.

SIGNATURE ______________________ **DATE** ______________________

PATIENT NAME:_________________________________ **DATE:**_______________________________

MEDICAL HISTORY FORM

Answer the following questions by checking Yes or No, whichever applies. Your answers are for our records only and will be considered confidential.

____Yes _____No Are you in good health?
____Yes _____No Has there been any change in your health since last year?
When was your last physical exam? (date)____________________
____Yes _____No Are you now under the care of a physician?
If yes, for what condition?________________________________
Physician name:_____________________________________
Address:____
Phone #:____
____Yes _____No Have you had any serious illness or hospitalization in the past 5 years?
____Yes _____No Are you taking any medicine(s) including non-prescription? Please list:_________________
____

Do you have, or have you had, any of the following disease or problems?

____Yes _____No Damaged heart valves, artificial valves or murmur? (Please circle which one)
____Yes _____No Rheumatic Heart Disease / Rheumatic fever?
____Yes _____No Heart trouble, heart attack, angina, high blood pressure, stroke arteriosclerosis or any other heart condition? (Please circle which one)
Explain:____
____Yes _____No Chest pain on exertion?
____Yes _____No Shortness of breath after mild exercise?
____Yes _____No Do your ankles swell?
____Yes _____No Allergy?
____Yes _____No Sinus trouble?
____Yes _____No Asthma or hay fever?
____Yes _____No Fainting spells or seizures?
____Yes _____No Diabetes? Is it under control?_____________________________
____Yes _____No Hepatitis, jaundice or liver disease?
____Yes _____No Frequent or recurring mouth sores?
____Yes _____No Thyroid problems?
____Yes _____No Respiratory problems, emphysema, bronchitis, etc.?
____Yes _____No Arthritis or painful, swollen joints?
____Yes _____No Stomach ulcer or hyperacidity?
____Yes _____No Kidney trouble?
____Yes _____No Tuberculosis?
____Yes _____No Persistent cough or cough that produces blood?
____Yes _____No Persistent swollen neck glands?
____Yes _____No Low blood pressure?
____Yes _____No Epilepsy or neurological disorder?
____Yes _____No Problems with mental health?
____Yes _____No Cancer?
____Yes _____No Problems of the immune system?
____Yes _____No Have you had radiation therapy?
____Yes _____No Do you smoke or use smokeless tobacco? If so, for how long?______________________
____Yes _____No Do you or your family have a history of oral cancer?
____Yes _____No Do you use alcohol?
____Yes _____No Have you had abnormal bleeding?
____Yes _____No Have you ever required a blood transfusion?
____Yes _____No Do you have any blood disorder such as anemia?

MEDICAL HISTORY FORM (Cont.)

____Yes _____No Have you ever had treatment for a tumor or growth?
____Yes _____No Do you have any artificial implants or joints? Where?________________________________

Are you allergic or have you had a reaction to:

____Yes _____No Local anesthetics
____Yes _____No Penicillin
____Yes _____No Sulfas drugs
____Yes _____No Other antibiotics (please list):________________________________
____Yes _____No Barbiturates or sleep pills
____Yes _____No Aspirin
____Yes _____No Iodine
____Yes _____No Codeine or other narcotics
____Yes _____No Other:________________________________
____Yes _____No Have you had any serious trouble associated with previous dental treatment? If so, explain: ________________________________
____Yes _____No Do you have any other condition or disease you think the doctor should know about? If so, explain: ________________________________
____Yes _____No Are you wearing contact lenses?
____Yes _____No Are you wearing removable dental appliances?

Women:

____Yes _____No Are you pregnant? How many weeks?________________________________
____Yes _____No Do you have problems associated with your menstrual period?________________________
____Yes _____No Are you nursing?
____Yes _____No Are you taking birth control pills?

Chief Dental Complaint: ____
____

Warning: If you are currently taking or have taken a bisphosphonate drug (such as **Fosamax**, **Actonel** or **Boniva**) for osteoporosis or osteopenia, be aware that there is a potential for developing osteonecrosis, a condition that results in failure to heal and can lead to other lethal complications (bone and tissue destruction, possible disfigurement). In the event that you develop osteonecrosis, you may need to be referred to a specialist or to a hospital for additional treatment. Any and all resulting treatment will be at an additional cost to the patient. IT IS EXTREMELY IMPORTANT THAT YOU INFORM YOUR DOCTOR IF YOU ARE TAKING OR HAVE TAKEN ONE OF THESE DRUGS. IT IS ALSO VERY IMPORTANT THAT YOU KEEP YOUR POSTOPERATIVE APPOINTMENTS AND INFORM THE DOCTOR IF YOU FAIL TO HEAL PROPERLY. **Warning:** Taking any antibiotic will dilute the effect of birth control pills. It is advised that you use other means of birth control.

I authorize Lalji Dental P.C. to examine my (and/or my child's) teeth and take any x-rays they deem necessary for diagnosis. I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold my dentist or any member of the staff responsible for errors or omissions that I may have made in the completion of this form. I understand that I am responsible for payment of any treatment rendered. All x-rays and records are property of Lalji Dental P.C.

______________________________________ ______________________
Signature (Patient/Parent/Legal Guardian) Date

Date	Comments	Doctor's Signature