JANOFF & KHATRI
PEDIATRIC DENTISTRY

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Name: _____ Nickname: _____

Gender Identity: ☐ Male ☐ Female ☐ Genderqueer/Non-Binary ☐ Fill in the blank _____

Birthdate: _____ Purpose of visit: _____

Concerns: _____ Email: _____

Siblings names and ages: _____

Is your child adopted *(we ask for medical history purposes)* : ☐ Yes ☐ No Child's Interests: _____

Name of Pet(s): _____ Does your child have any special needs? _____

_____ Any phobias? _____

Child's learning: ☐ Slow ☐ Average ☐ Accelerated Child's school: _____

Who may we thank for referring you to us? _____

HEALTH HISTORY

Child's Pediatrician: _____ Phone Number: _____ Last Physical: _____

Pediatrician's address: _____

Is your child under a physician's care now? ☐ Yes ☐ No If yes, reason? _____

Is your child taking any medications (including over-the-counter)? ☐ Yes ☐ No If yes, please list: _____

Is your child allergic to any medication? ☐ Yes ☐ No If yes, please list: _____

Does your child have allergic reaction to: ☐ food(s) ☐ animals ☐ pollen ☐ dust ☐ latex ☐ eggs

Other allergies: _____

Has your child had a history or difficulty with any of the following (please complete the chart below)?

	Yes	No		Yes	No		Yes	No
TMJ problems	☐	☐	Premature	☐	☐	Speech Disorder	☐	☐
Diabetes	☐	☐	Brain Injury	☐	☐	Sinus Problems	☐	☐
Allergies to Medications	☐	☐	Bleeding	☐	☐	Earaches Infections	☐	☐
Liver/Jaundice	☐	☐	Hepatitis	☐	☐	Tuberculosis	☐	☐
Heart	☐	☐	Immune Disorders	☐	☐	Bruising	☐	☐
Rheumatic Fever	☐	☐	ADHD/ADD	☐	☐	Cancer/Malignancies	☐	☐
Seizures	☐	☐	Autism	☐	☐	Down Syndrome	☐	☐
Depression/Anxiety	☐	☐	Sensory Issues	☐	☐	Kidney	☐	☐
Cerebral Palsy	☐	☐	Delayed Development	☐	☐	Hearing	☐	☐
Bladder	☐	☐	Bone Disorder	☐	☐	Nosebleeds	☐	☐
Asthma	☐	☐	Eating Disorder	☐	☐	Emotional/School Problems	☐	☐
Date Last Asthma attack	☐	☐	Tooth or gum pain	☐	☐	Other: _____		

If yes to any of the symptoms on the previous page, please explain: _____

_____

_____

_____

_____

DENTAL HISTORY

Is this your child's first dental visit? ☐ Yes ☐ No If no, previous dentist: _____

Phone number: _____ Date of last visit: _____

How was his/her experience? _____ Were any x-rays taken: _____

Child's attitude towards the dentist or dental care:

Has your child had any injuries to teeth, mouth, or head? ☐ Yes ☐ No

If yes, please describe: _____

Please check any of your child's habits: _____

☐ Thumb/finger ☐ Pacifier ☐ Nail Biting ☐ Mouth Breathing ☐ Snoring ☐ Teeth Grinding ☐ Nursing ☐ Bottle Feeding

Is your water fluoridated? _____ Does your child take fluoride supplements? _____

Does your child use fluorinated toothpaste? _____ How often does your child floss? _____

How often does your child brush his/her teeth? _____ With adult supervision? _____

How may we help make this a positive experience for your child? _____

GENERAL INFORMATION

Guardian One: _____ SSN: _____

Relationship to Patient: _____ Birthdate: _____ Driver's license #: _____

Guardian Two: _____ SSN: _____

Relationship to Patient: _____ Birthdate: _____ Driver's license #: _____

Are Guardians: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Partners

Child lives with: ☐ Both Guardians ☐ Guardian One ☐ Guardian Two ☐ Other : _____

Person financially responsible for child's dental care: _____

Home address: _____

Guardian One Employer: _____ Occupation: _____ Work Ph: _____

Business Address: _____ Cell Ph: _____

Guardian Two Employer: _____ Occupation: _____ Work Ph: _____

Business Address: _____ Cell Ph: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ _____ Cell Phone: _____

I hereby give Dr Khatri permission to complete an oral exam and radiographs (x-rays) for diagnostic purposes. 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 the office of any changes in my child's health status.

Signature: _____ Relationship: _____

INSURANCE INFORMATION

Do you have dental insurance coverage for you child? Yes No Who is the subscriber? ☐ Guardian One ☐ Guardian Two

Primary Insurance Company:_____ Insurance ID #:_____

Primary Insurance Company Phone:_____ Group or Policy Number:_____

Address of Primary Insurance Company:_____

Secondary Insurance Company: _____ Insurance ID #: _____

Secondary Insurance Company Phone: _____ Group or Policy Number: _____

Address of Secondary Insurance Company: _____

I hereby authorize the dentist to release any information including diagnosis and records to the third-party payer and/or other health care practitioners. I authorize and request my insurance to pay directly to the above-named dentist, otherwise payable to me but not to exceed the charges shown on the claim. This office is not responsible for any insurance company's arbitrary determination of payment, which procedures are covered under the plan, frequency of procedures performed, or period taken to process claims. I realize that the failure to keep this account current may result in the dentist being unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. As a courtesy to you, we will complete and file insurance forms relative to dental treatment and will do our best to collect all fees due from the insurance carrier. However, fees not paid by your insurance company within 60 days are due and payable by the patient's guardian.

Responsible Party Policy:

Due to the prevalence of divorce situations, it is the policy of this office to collect from the guardian who brings the child in for dental services.

Office Policies:

Unless appointments are canceled at least 24 hours in advance, our policy is to charge for missed appointments at the rate of a normal office visit. We do attempt to confirm appointments but do so only as a courtesy. The guardian is ultimately responsible for any scheduled appointments made for the child.

I acknowledge that I have read and agreed to the above policies.

SIGNATURE: _____ Relationship: _____ Date: _____

Acknowledgment of receipt of NOTICE OF PRIVACY PRACTICES (HIPPA)

*You may refuse to sign this portion of the acknowledgment *

I, _____ Acknowledgment of receipt of NOTICE OF PRIVACY PRACTICES (HIPPA)

*You may refuse to sign this portion of the acknowledgment *

SIGNATURE: _____ Relationship: _____ Date: _____