



# All Smiles Children's Dentistry

## Houri Fatourachi, DDS

### Patient Registration

🌐 Child's Name: \_\_\_\_\_ Nickname: \_\_\_\_\_

🌐 Child's Date of Birth: \_\_\_\_\_

🌐 Child's Address: \_\_\_\_\_

🌐 Reason for Visit/Chief Complaint: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

◆ Father's Name: \_\_\_\_\_

◆ Father's Date of Birth: \_\_\_\_\_

◆ Father's Address: \_\_\_\_\_

◆ City: \_\_\_\_\_ Zip code: \_\_\_\_\_

◆ Father's Phone Number: \_\_\_\_\_

◆ Cell Phone Number: \_\_\_\_\_

◆ Father's E-mail Address: \_\_\_\_\_

#### **INSURANCE INFORMATION**

◆ Father's Insurance Company: \_\_\_\_\_

Insurance ID or Social Security #: \_\_\_\_\_

Father's Employer: \_\_\_\_\_

❖ Mother's Name: \_\_\_\_\_

❖ Mother's Date of Birth: \_\_\_\_\_

❖ Mother's Address: \_\_\_\_\_

❖ City: \_\_\_\_\_ Zip code: \_\_\_\_\_

❖ Mother's Phone Number: \_\_\_\_\_

❖ Cell Phone Number: \_\_\_\_\_

❖ Mother's E-mail Address: \_\_\_\_\_

#### **INSURANCE INFORMATION**

❖ Mother's Insurance Company: \_\_\_\_\_

Insurance ID or Social Security #: \_\_\_\_\_

Mother's Employer: \_\_\_\_\_

Whom may we thank for referring you to our office? \_\_\_\_\_

# Medical History

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

- Is your child under a physician's care now?  Yes  No
- Has your child ever been hospitalized or had a major operation?  Yes  No
- Is your child taking any medications, pills, or drugs?  Yes  No
- Is your child taking or has he taken Phen-Fen or Redux?  Yes  No
- Is your child on a special diet?  Yes  No

Is your child allergic to any of the following?

- Aspirin     Penicillin     Codeine     Acrylic     Metal     Latex     Local Anesthetics
- Other    If 'other', please explain: \_\_\_\_\_

Does your child have, or has had, any of the following?

- |                           |  |                           |  |                       |  |                            |  |
|---------------------------|--|---------------------------|--|-----------------------|--|----------------------------|--|
| AIDS/HIV Positive         | <input type="radio"/> Yes <input type="radio"/> No | Cortisone Medicine        | <input type="radio"/> Yes <input type="radio"/> No | Hemophilia            | <input type="radio"/> Yes <input type="radio"/> No | Renal Dialysis             | <input type="radio"/> Yes <input type="radio"/> No |
| Alzheimer's Disease       | <input type="radio"/> Yes <input type="radio"/> No | Diabetes                  | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis A           | <input type="radio"/> Yes <input type="radio"/> No | Rheumatic Fever            | <input type="radio"/> Yes <input type="radio"/> No |
| Anaphylaxis               | <input type="radio"/> Yes <input type="radio"/> No | Drug Addiction            | <input type="radio"/> Yes <input type="radio"/> No | Hepatitis B or C      | <input type="radio"/> Yes <input type="radio"/> No | Rheumatism                 | <input type="radio"/> Yes <input type="radio"/> No |
| Anemia                    | <input type="radio"/> Yes <input type="radio"/> No | Easily Winded             | <input type="radio"/> Yes <input type="radio"/> No | Herpes                | <input type="radio"/> Yes <input type="radio"/> No | Scarlet Fever              | <input type="radio"/> Yes <input type="radio"/> No |
| Angina                    | <input type="radio"/> Yes <input type="radio"/> No | Emphysema                 | <input type="radio"/> Yes <input type="radio"/> No | High Blood Pressure   | <input type="radio"/> Yes <input type="radio"/> No | Shingles                   | <input type="radio"/> Yes <input type="radio"/> No |
| Arthritis/Gout            | <input type="radio"/> Yes <input type="radio"/> No | Epilepsy or Seizures      | <input type="radio"/> Yes <input type="radio"/> No | Hives or Rash         | <input type="radio"/> Yes <input type="radio"/> No | Sickle Cell Disease        | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Heart Valve    | <input type="radio"/> Yes <input type="radio"/> No | Excessive Bleeding        | <input type="radio"/> Yes <input type="radio"/> No | Hypoglycemia          | <input type="radio"/> Yes <input type="radio"/> No | Sinus Trouble              | <input type="radio"/> Yes <input type="radio"/> No |
| Artificial Joint          | <input type="radio"/> Yes <input type="radio"/> No | Excessive Thirst          | <input type="radio"/> Yes <input type="radio"/> No | Irregular Heartbeat   | <input type="radio"/> Yes <input type="radio"/> No | Spina Bifida               | <input type="radio"/> Yes <input type="radio"/> No |
| Asthma                    | <input type="radio"/> Yes <input type="radio"/> No | Fainting Spells/Dizziness | <input type="radio"/> Yes <input type="radio"/> No | Kidney Problems       | <input type="radio"/> Yes <input type="radio"/> No | Stomach/Intestinal Disease | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Disease             | <input type="radio"/> Yes <input type="radio"/> No | Frequent Cough            | <input type="radio"/> Yes <input type="radio"/> No | Leukemia              | <input type="radio"/> Yes <input type="radio"/> No | Stroke                     | <input type="radio"/> Yes <input type="radio"/> No |
| Blood Transfusion         | <input type="radio"/> Yes <input type="radio"/> No | Frequent Diarrhea         | <input type="radio"/> Yes <input type="radio"/> No | Liver Disease         | <input type="radio"/> Yes <input type="radio"/> No | Swelling of Limbs          | <input type="radio"/> Yes <input type="radio"/> No |
| Breathing Problem         | <input type="radio"/> Yes <input type="radio"/> No | Frequent Headaches        | <input type="radio"/> Yes <input type="radio"/> No | Low Blood Pressure    | <input type="radio"/> Yes <input type="radio"/> No | Thyroid Disease            | <input type="radio"/> Yes <input type="radio"/> No |
| Bruise Easily             | <input type="radio"/> Yes <input type="radio"/> No | Genital Herpes            | <input type="radio"/> Yes <input type="radio"/> No | Lung Disease          | <input type="radio"/> Yes <input type="radio"/> No | Tonsillitis                | <input type="radio"/> Yes <input type="radio"/> No |
| Cancer                    | <input type="radio"/> Yes <input type="radio"/> No | Glaucoma                  | <input type="radio"/> Yes <input type="radio"/> No | Mitral Valve Prolapse | <input type="radio"/> Yes <input type="radio"/> No | Tuberculosis               | <input type="radio"/> Yes <input type="radio"/> No |
| Chemotherapy              | <input type="radio"/> Yes <input type="radio"/> No | Hay Fever                 | <input type="radio"/> Yes <input type="radio"/> No | Pain in Jaw Joints    | <input type="radio"/> Yes <input type="radio"/> No | Tumors or Growths          | <input type="radio"/> Yes <input type="radio"/> No |
| Chest Pains               | <input type="radio"/> Yes <input type="radio"/> No | Heart Attack/Failure      | <input type="radio"/> Yes <input type="radio"/> No | Parathyroid Disease   | <input type="radio"/> Yes <input type="radio"/> No | Ulcers                     | <input type="radio"/> Yes <input type="radio"/> No |
| Cold Sores/Fever Blisters | <input type="radio"/> Yes <input type="radio"/> No | Heart Murmur              | <input type="radio"/> Yes <input type="radio"/> No | Psychiatric Care      | <input type="radio"/> Yes <input type="radio"/> No | Venereal Disease           | <input type="radio"/> Yes <input type="radio"/> No |
| Congenital Heart Disorder | <input type="radio"/> Yes <input type="radio"/> No | Heart Pace Maker          | <input type="radio"/> Yes <input type="radio"/> No | Radiation Treatments  | <input type="radio"/> Yes <input type="radio"/> No | Yellow Jaundice            | <input type="radio"/> Yes <input type="radio"/> No |
| Convulsions               | <input type="radio"/> Yes <input type="radio"/> No | Heart Trouble/Disease     | <input type="radio"/> Yes <input type="radio"/> No | Recent Weight Loss    | <input type="radio"/> Yes <input type="radio"/> No |                            |  |

Any other not listed above? If yes, please explain \_\_\_\_\_

- Has your child ever been to the Dentist before?  Yes  No
- Has your child had an unfavorable experience at another office?  Yes  No
- If yes, please explain: \_\_\_\_\_

- Has your child had Nitrous Oxide before?  Yes  No
- How do you think your child will act toward the dentist? \_\_\_\_\_

- How do you think your child will act toward the dentist? \_\_\_\_\_
- How many times per day does your child brush his/her teeth? \_\_\_\_\_ Is dental floss used? \_\_\_\_\_

- Is fluoride taken in any form? (Water, tablets, etc)  Yes  No
- Does your child have a history of finger sucking \_\_\_\_\_ lip sucking \_\_\_\_\_ Nail biting \_\_\_\_\_ pacifier \_\_\_\_\_ Bottle? \_\_\_\_\_
- How old was your child when he/she discontinued bottle use or nursing? \_\_\_\_\_

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information ca be dangerous to my child 's health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PARENT OR GUARDIAN \_\_\_\_\_ DATE \_\_\_\_\_