

## JOANNE RAHMAN, DDS, MS

Date:	
Patient Informat	<u>tion</u>
Child's Full Name	Age Sex (M) (F)
Nickname (if any)Birthda	ate
Whom may we thank for referring you	
General Informa	tion
Father/Stepfather/Partner/Legal Guardian Information:	
Name: SSN:	Birthdate:
Home Address	
Home Phone:	Cell Phone:
Employer:	
Business Address:	Work Phone:
Occupation:	
E-mail:	
Is it okay to contact this parent on your cellular number? Yes	No
Is it okay to contact this parent via e-mail? Yes No	
Mother/Stepmother/Partner/Legal Guardian Information:	
Name: SSN:	Birthdate:
Home Address	
Home Phone:	Cell Phone:
Employer:	
Business Address:	Work Phone:
Occupation:	
E-mail:	
Is it okay to contact this parent on your cellular number? Yes	No
Is it okay to contact this parent via e-mail? Yes No	
Parent(s) are: Married Divorced Single Widowed Partners	Child lives with:
Person Financially responsible	-
Emergency Contact	Phone
SIGNATURER	Relationship



## **Health History**

Patient Name:	Date of Birth:				
		So	cial History		
What is your child most interested in?					
Names of brothers/sister					
Name of Pets				_	
Reason for today's visit					
Child's school			<del></del>		
		Med	dical History		
Child's pediatrician:		Т	elephone #		
Congenital Heart Problems / Murmurs /	(Y)	(N)	Bone Disorder	(Y)	(N)
Rheumatic Fever Growth & Development (learning, behavioral)	(Y)	(N)	Cancer/Malignancy	(Y)	(N)
, ,	(Y)	(N)	Chemo/Radiation Therapy	(Y)	(N)
Down's Syndrome Autism	(Y)	(N)	Cystic Fibrosis	(Y)	(N)
Learning disabilities	(Y)	(N)	Allergies (if Yes, see below)	(Y)	(N)
Respiratory System / Pneumonia / Asthma			Allergies to Medication		
	(Y)	(N)	-	(Y)	(N)
Tuberculosis	(Y)	(N)	Endocrine / Diabetes	(Y)	(N)
Anemia	(Y)	(N)	Extremities/Arthritis/Joint problems	(Y)	(N)
Blood Disorders / Bruising	(Y)	(N)	ADHD/ADD	(Y)	(N)
Skin Problems / Cold Sores / Canker Sores	(Y)	(N)	Central Nervous System/Epilepsy/Seizure	(Y)	(N)
Hepatitis	(Y)	(N)	Bladder problems	(Y)	(N)
Brain Injury	(Y)	(N)	Cerebral Palsy	(Y)	(N)
Earaches/Infections	(Y)	(N)	Emotional/School Problems/Depression/Anxiety	/ (Y)	(N)
Hearing Impaired	(Y)	(N)	GI – stomach, intestinal, liver, jaundice	(Y)	(N)
Hospitalization	(Y)	(N)	Eating Disorder	(Y)	(N)
Has your child had any unfavorable reactions	s to drugs, ar	ntibiotics, o	or anesthetics? (Y) (N)		
If yes, please list					
Is your child currently taking any medications	s? (Y) (N) Wh	at kind?			
Is your child protected by immunizations? (Y					
Is your child taking any supplemental fluoride			pply)MedicationsLatex/Rubber	Pollon/Dust	Anasthatia
			er Foods . If so, please list:		_Anesmenc
			ntal History		
Is this your child's dental first visit? (Y)(N)	f no provious	dontiat?	Dhone		
			Were X-ray		
			ase describe:		
Does your child have any of the following ha		. , . ,		cifier	
Nail-biting Lip-sucking Mouth-breathing				onioi	
		Ü	, and the second		
Does your child currently use a bottle? (Y) (N					
			Does your child currentl	y nurse? (Y) (N)	
How often does your child brush his/her teet	h per day? _	Do y	you help? (Y) (N)		
How often does your child floss?		Do :	you floss your child's teeth? (Y) (N)		
and it is my responsibility to inform the office of any	y changes in my am accepting a	y child's hea Il responsibi	inor. I understand that the information I have given alth status. I authorize the dental staff to perform any lity for full payment of services rendered regardless indered.	v necessary dental se	rvices my child
Parent/Guardian Signature:				Date	
Doctorio Cinnatino				Data	
Doctor's Signature:				Date	



## JOANNE RAHMAN, DDS, MS

## **Insurance Information**

Primary Insurance Company		Phone Number
Subscriber	Birthdate	Group Number
Secondary Insurance Company		Phone Number
Subscriber	Birthdate	Group Number
child receives. However, in the event the	insurance company, for any you. You understand that th	insurance company listed above for treatments youreason, does not pay, the balance will become you is contract is with San Ramon Children's Dentistry is on the account.
SIGNATURE OF RESPONSIBLE PARTY	<i>(</i>	
Relationship	D	ate