



**S.M. HAIDER, D.D.S.**

Pediatric Dentistry • Facial Orthopedics • Orthodontics

**PATIENT ACQUAINTANCE INFORMATION**

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth \_\_\_\_\_

Prefers to be called \_\_\_\_\_ Sex \_\_\_\_\_ Weight \_\_\_\_\_

**I. CHILD'S MEDICAL HISTORY**

- |  | Yes                                | No   |
|--|------------------------------------|--|
| 1. Does child have a health problem?   | <input type="checkbox"/>           | <input type="checkbox"/>                     |
| 2. Is child under care of physician now?   | <input type="checkbox"/>           | <input type="checkbox"/>                     |
| 3. Is there any history or excessive bleeding in child or family?                        | <input type="checkbox"/>           | <input type="checkbox"/>                     |
| 4. Has child ever had any emotional, mental, or nervous problem?                         | <input type="checkbox"/>           | <input type="checkbox"/>                     |
| 5. Has child experienced any unfavorable reactions to any drugs?                         | <input type="checkbox"/>           | <input type="checkbox"/>                     |
| 6. Regular medications being taken by child _____  |                                    |  |
| 7. Medicines or drugs to which child is allergic _____                                   |                                    |  |
| 8. Any other allergies _____   |                                    |  |
| 9. Previous hospitalizations _____   |                                    |  |
| 10. Has child had any history or difficulty with the following? If so, please check ( ). |                                    |  |
| <input type="checkbox"/> Heart   | <input type="checkbox"/> Anemia    | <input type="checkbox"/> Chicken Pox         |
| <input type="checkbox"/> Lungs   | <input type="checkbox"/> Asthma    | <input type="checkbox"/> Bleeding Disorders  |
| <input type="checkbox"/> Liver   | <input type="checkbox"/> Fainting  | <input type="checkbox"/> Epilepsy            |
| <input type="checkbox"/> Kidney  | <input type="checkbox"/> Diabetes  | <input type="checkbox"/> Convulsions         |
| <input type="checkbox"/> Hepatitis   | <input type="checkbox"/> Mumps     | <input type="checkbox"/> Tuberculosis        |
| <input type="checkbox"/> Hearing   | <input type="checkbox"/> Measles   | <input type="checkbox"/> Malignancy          |
| <input type="checkbox"/> Handicap/Disabilities   | <input type="checkbox"/> HIV+/AIDS | <input type="checkbox"/> Rheumatic Fever     |
|  |                                    | <input type="checkbox"/> Cleft lip or Palate |
|  |                                    | <input type="checkbox"/> Cerebral Palsy      |
|  |                                    | <input type="checkbox"/> Rheumatic Fever     |
|  |                                    | <input type="checkbox"/> Speech Problems     |
|  |                                    | <input type="checkbox"/> Chronic Sinusitis   |
|  |                                    | <input type="checkbox"/> Heart Murmur        |
|  |                                    | <input type="checkbox"/> Allergies to Latex  |

DOCTORS NOTES:

**II. CHILD'S DENTAL HISTORY**

- |   | YES                      | NO                       |
|---|--------------------------|--------------------------|
| 1. Has child ever had a local anesthetic?                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has child had any unfavorable dental experiences?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Had child had any injuries to the mouth or teeth?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Does child have a toothache now?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has child recently had a toothache?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Does child have any mouth habits? (thumbsucking, nailbiting, mouthbreathing) | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Does child have TMJ problems?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Does child have a bite problem?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Last dental examination _____  |                          |                          |
| 10. Last dental X-rays _____  |                          |                          |
| 11. Last topical fluoride treatment _____                                       |                          |                          |
| 12. Reason for this visit _____   |                          |                          |

Please identify any dental or medical problem of special concern or provide any other information which you think might be important in the care of your child. \_\_\_\_\_



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III. GENERAL INFORMATION

1. Child's Name \_\_\_\_\_
2. Parent's Names:  
Father \_\_\_\_\_ Mother \_\_\_\_\_
3. Home Address \_\_\_\_\_ Home Phone \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_
4. Occupation and place of employment  
Father \_\_\_\_\_ Bus Phone \_\_\_\_\_  
Mother \_\_\_\_\_ Bus Phone \_\_\_\_\_
5. Parent or guardian responsible for this account  
Name \_\_\_\_\_
6. Dental Insurance Carrier (if applicable) \_\_\_\_\_  
Policy No. \_\_\_\_\_ S.S. # \_\_\_\_\_
7. What other children in your family have we seen? \_\_\_\_\_
8. Parent's Dentist \_\_\_\_\_
9. Child's Pediatrician (physician) \_\_\_\_\_
10. Who referred your child to our office? \_\_\_\_\_

IV. CONSENT FOR TREATMENT OF A MINOR:

The undersigned hereby authorizes Dr. Haider to perform the examination including x-rays and, after explanation, all forms of treatment, medication, and therapy indicated for the dental care of the above named child. This consent shall remain in full force and effect until cancelled by either party.

Signed \_\_\_\_\_

Relationship \_\_\_\_\_ Date \_\_\_\_\_

All fees for services rendered are payable at the conclusion of each appointment unless other financial arrangement have been made. All account in excess of five weeks past due are subject to a late charge.