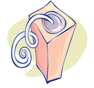
Arleen Azar-Mehr, D.D.S., M.S.



9535 Reseda Blvd., Suite 206, Northridge, CA 91324
Phone: 818-886-6666 ● Fax: 818-886-6662 ● www.losangelesorthodontist.com

Today's Date________________

About Your Child

Child's Name:_________________________Nickname:___________□Female □Male Date of Birth: __/__/__ Age:_____Grade:______

Child's Address:____________________________Unit #________City:_______________State:____Zip:_________SS #:____________

Child's Home #: (____)_____________School:_________________________Hobbies/Sports:___________________________________

General Information

Child's General Dentist:______________________Dentist's Phone #:(____)___________Dentist's Address:_____________________________

Who is bringing the child today? Name:________________________Relation:______________Do you have legal custody of this child? □Yes □No

Whom may we thank for referring you?______________________Other Siblings:____________________Child's Email:__________________

Relative or Friend not living with you:___________________Phone #:(___)____________Address:____________________________________

Parents Information

Who is responsible for account? □Mother □Father □Guardian Parent's Marital Status: □Single□Married□Divorced□Separated□Partnered□Widowed

□ Father □ Stepfather □ Guardian Name:________________________________Date of Birth: ___/___/___ DL#:___________________

Home #:(____)__________________ Cell #:(___)_______________Wk #:(___)___________________Email:________________________

Address: (If different than Child's)____________________________City:_____________State:____Zip:_________□Own □Rent How Long?___

Employer:______________________Position:____________________Employer Address:____________________________How long?_____

Dental Insurance Coverage □ Yes □ No Insurance Co.Name:______________________________Insured's Name:____________________

Insurance Co. Address:__________________________City:_________________State:____Zip:_______Insurance Phone #:_____________

SS #:____________________________Insured's ID #:___________________________________Group #:_________________________

□ Mother □ Stepmother □ Guardian Name:________________________________Date of Birth: ___/___/___ DL#:________________

Home #:(____)__________________ Cell #:(___)_______________Wk #:(___)___________________Email:______________________

Address: (If different than Child's)____________________________City:_____________State:____Zip:_________□Own □Rent How Long?___

Employer:______________________Position:____________________Employer Address:____________________________How long?______

Dental Insurance Coverage □ Yes □ No Insurance Co.Name:______________________________ Insured's Name:_________________

Insurance Co. Address:__________________________City:_________________State:____Zip:_______Insurance Phone #:_____________

SS #:____________________________Insured's ID #:___________________________________Group #:__________________________

Authorization

I agree and accept that this office reserves the right to verify credit status of potential patients and/or parents prior to extending credit for treatment fees and may, at the discretion of this office, use the services of one or more credit reporting services. If this office accepts insurance, I understand that I am responsible for payment of services rendered. I understand I am responsible for paying any co-payment and deductibles my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits and, I assign directly to the doctor, all insurance benefits otherwise payable to me. I further authorize the use of my signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian **Date**

Dental & Medical History

What is your main concern for your child?______________________________

Question	Yes	No
Has your child been evaluated or had orthodontic treatment before?	□ Yes	□ No
Does your child require antibiotics prior to dental treatment?	□ Yes	□ No
Have there been any injuries to the mouth, teeth, chin or face?	□ Yes	□ No
Does your child have any missing or extra teeth?	□ Yes	□ No
Does your child brush their teeth daily?	□ Yes	□ No
Has your child ever had any pain or tenderness in their jaw joint (TMJ/TMD)?	□ Yes	□ No
Have their tonsils or adenoids been removed?	□ Yes	□ No
Does your child floss their teeth daily?	□ Yes	□ No
Has puberty begun?	□ Yes	□ No
Has menstruation begun? (If Female)	□ Yes	□ No
Are your child's immunizations current?	□ Yes	□ No
Is there anything you would like to discuss with the Doctor in private?	□ Yes	□ No
Has your child ever taken any diets pills, such as Phen-Fen?	□ Yes	□ No

(Also known as Redux or Pondimin.) If so when? ______________________________

Is your child currently under the care of a physician? □ Yes □ No

Child's Physician:____________________Phone #:(___)______________Date of Last Visit:_____

Please describe your child's current physical heath: □ Good □ Fair □ Poor

Please list any musical instruments your child plays:______________________________

Please list all drugs that your child is currently taking?______________________________

Please discuss any serious medical problems your child has had:______________________________

Is your child allergic to: Latex Y N Nickel or Metal Y N Plastic Y N Other:______________________

Has your child experienced any of the following medical problems?

Condition	Y	N	Condition	Y	N
Abnormal Bleeding	Y	N	Heart Murmur	Y	N
ADD or ADHD (circle one please)	Y	N	Hemophilia	Y	N
AIDS or HIV (circle one please)	Y	N	Hepatitis	Y	N
Artificial Bones/Joints/Valves	Y	N	Kidney Problems	Y	N
Asthma	Y	N	Liver Problems	Y	N
Cancer	Y	N	Mitral Valve Prolapse	Y	N
Congenital Heart Defect	Y	N	Prosthetics	Y	N
Diabetes	Y	N	Rheumatic Fever	Y	N
Disabilities	Y	N	Scarlet Fever	Y	N
Epilepsy	Y	N	Seizures	Y	N
Handicaps	Y	N	Sickle Cell Disease	Y	N
Hearing Impairment	Y	N	Tuberculosis (TB)	Y	N

Does or did your child have any of the following habits?

Habit	Y	N	Habit	Y	N
Breast Fed	Y	N	Nursing Bottle Habits	Y	N
Clenching or Grinding Teeth	Y	N	Speech Problems	Y	N
Lip Sucking or Biting	Y	N	Thumb or Finger Sucking	Y	N
Mouth Breather	Y	N	Tongue Thrust	Y	N
Nail Biting	Y	N	Used a Pacifier	Y	N

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental/orthodontic services my child may need.

Signature of Parent or Guardian **Date**

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I have verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

Signature of Dentist Date

Dentist's Comments: ______________________________

Has there been any change in your child's health status since their last visit? □ Y □ N

If Yes, please explain:______________________________

Parent Guardian Signature **Date**

Dentist Signature Date

Has there been any change in your child's health status since their last visit? □ Y □ N

If Yes, please explain:______________________________

Parent or Guardian Signature **Date**

Dentist Signature Date