Niloofar Mofakhami, DDS, PLLC **Date_____**
Children's Dentistry of Oakton

Name: Last _____ First_____ MI_____ Preferred_____
Date of birth_____ Age _____ ○ Male ○ Female
Home address_____ City _____ State ____ Zip _____
Home phone_____ School_____ Grade_____
Name/age of other children in family_____

Parent/guardian's name _____ Relationship: _____
Cell phone _____ Email address: _____
Parent's employer_____ Office phone _____

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Cell phone _____ Email address: _____
Parent's employer_____ Office phone _____

Dental insurance _____Group #_____ ID#_____
Subscriber name_____ SSN_____ Date of birth _____
Insurance company address _____

Whom may we thank for referring you to us? _____
What is the reason for your child's dental visit? _____

Health History

○ Yes ○ No Is your child in good health?
Name of child's physician_____
Phone number for child's physician _____
Date of last physical exam_____
○ Yes ○ No Does your child have any allergies? _____
○ Yes ○ No Has your child ever been hospitalized? Please give reason and dates. _____
_____
○ Yes ○ No Is your child currently taking any medications? Please give medication name and reason._____
○ Yes ○ No Were there any problems at birth? _____

Does your child have or ever had any of the following diseases or conditions:

○ Heart disease	○ Bleeding/transfusions	○ Asthma	○ Blood dyscrasias
○ Liver/GI disease	○ Recurrent headaches	○ Diabetes	○ Anemia
○ Kidney disease	○ Rheumatic fever	○ Hepatitis	○ Mental delays
○ Speech/hearing	○ Seizures	○ Cleft lip/palate	○ Physical delays
○ Cerebral palsy	○ Congenital birth defects	○ Personality/social	○ Cancer/tumors
○ HIV+/AIDS	○ Frequent infections	○ Autism	○ADD/ADHD
○ Mouth breathing	○ Snoring	○ Other	

Please elaborate on any items checked _____
_____
_____
_____
_____

Dental History

○ Yes ○ No Has your child ever been to the dentist?
Name of dentist_____ Date of last visit/x-rays_____
○ Yes ○ No Has your child experienced any unfavorable reaction from previous dental care?
_____
○ Yes ○ No Does your child suck a pacifier, finger, or thumb?
○ Yes ○ No Does your child have pain when chewing, yawning, or opening wide?

Does your child have problems with any of the following:

○ Cavities	○ Toothache	○ Sensitive teeth	○ Blisters/sores in/around the mouth
○ Trauma	○ Gum infections/swelling	○ Teeth discoloration	○ Tongue thrusting/sucking
○ Teeth grinding	○ Jaw sounds/discomfort	○ Bad breath	○ Other

Comments
_____
_____

Was your child: ○ breast fed? ○ bottle fed? At what age was it stopped? _____

Fluoride History

Is your home water supply fluoridated?	○ Yes	○ No	○ Don't Know
Does your child use a fluoride toothpaste?	○ Yes	○ No	○ Don't Know
Do you give your child any other form of fluoride?	○ Yes	○ No	○ Don't Know

Consent for Dental Treatment

I request and authorize Dr. Niloofar Mofakhami and her team to examine, clean, and provide dental treatment for my child's teeth. I further request and authorize x-rays to be taken, as necessary, to diagnose and/or treat my child's dental problems. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Mofakhami and her team will provide an environment that will help children learn to cooperate during treatment, including praise, explanations, demonstrations of procedures and instruments, and using variable voice tones. I understand that I have the opportunity to discuss all behavior management options with Dr. Mofakhami and her team prior to treatment. I will be responsible for any charges incurred for my child's dental treatment. It is my responsibility to inform Dr. Mofakhami's office of any changes to the information I have provided, including insurance coverage and medical history.

Signature_____ Date_____