Welcome to Dr. Mansour's Office!

Tell Us About Your Child

Child's Name:_____
First Last

Nickname:_____ Please Circle: Male Female

Child's Birthday:_____/_____/_____ Child's Age:_____

Child's Home#:_____ Child's SS#:_____

Child's Address:_____
Street City State Zip Code

Person Responsible For Account

Name:_____ Please Circle: Married Single Other
First Last Relationship:_____

SS#:_____

Parent's Birthday:_____ Email:_____

Home#:_____ Cell#:_____

Address:_____
Street City State Zip Code

Name of Person Accompanying Child Today:_____ Relationship:_____

Primary Dental Insurance

Insurance Company Name:_____ Group #:_____

Insurance Company Address: _____

Insurance Company Number:_____ Policy Owner's Employer:_____

Policy Owner's Name:_____ Relationship to Patient:_____

Policy Owner's Birthday:_____/_____/_____ Social Security #:_____

Secondary Dental Insurance

Insurance Company Name:_____ Group #:_____

Insurance Company Address: _____

Insurance Company Number:_____ Policy Owner's Employer:_____

Policy Owner's Name:_____ Relationship to Patient:_____

Policy Owner's Birthday:_____/_____/_____ Social Security #:_____

Dental History

Is this your child's first visit to the dentist? YES NO If not, how long since the last visit to the dentist?_____

Did he/she take x-rays? YES NO Did he/she receive a cleaning? YES NO

Have there been any injuries to the teeth, face, or mouth? YES NO

If so, Please Explain:_____

Why did you bring your child today?_____

Circle Any Habits Your Child May Have Listed Below:

Lip Sucking / Biting Nail Biting Baby Bottle Pacifier

Thumb Sucking Breast Feeding

Is your child's water fluoridated? YES NOIs your child taking fluoride supplements? YES NO

Does your child brush daily? YES NO Does your child floss daily? YES NO

Has your child ever had serious or difficult problems associated with previous dental work? YES NO

Has your child ever had pain or tenderness in his/her jaw/joint? YES

NO

Health History

YES NO	Abnormal Bleeding		YES NO	Handicap/Disabilities
YES NO	Allergies to any Drugs/Other		YES NO	Hearing Impairment
YES NO	Any Hospital Stays	YES NO	Heart Murmur	
YES NO	Any Operations		YES NO	Hemophilia
YES NO	Asthma		YES NO	Hepatitis
YES NO	Cancer		YES NO	HIV/AIDS
YES NO	Congenital Heart Disease		YES NO	Kidney/Liver Problems
YES NO	Convulsions/Epilepsy		YES NO	Rheumatic/Scarlet Fever
YES NO	Pregnancy		YES NO	Allergies to Latex Products

Please discuss any medical conditions or problems:_____

Please list all drugs or herbal supplements your child is current taking:_____

Please list all drugs, foods, or products your child may be allergic to:_____

Child's Physician: _____Child's Physician Number: _____

Is your child currently under the care of a physician? YES NO

Whom may we thank for referring us to you/How did you hear about our office ? _____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and 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 services my child may need.

Signature of Parent Guardian:_____ Date:_____