

WELCOME TO DR. SHOHREH SHARIF'S OFFICE

PATIENT INFORMATION

Last Name:		First Name:		M.I.:
DOB:	Age:	Nickname:	Male	Female
School:				Grade:

MEDICAL ALERTS

Please indicate Y/N for each

Y N	Heart Murmur
Y N	Cancer
Y N	Diabetes
Y N	Rheumatic Fever
Y N	HIV+/Aids
Y N	Hemophilia
Y N	Asthma
Y N	Hepatitis
Y N	Tuberculosis
Y N	Prosthesis
Y N	Abnormal Bleeding
Y N	Hearing Impairment
Y N	Congenital Heart Dis.
Y N	Convulsions/Epilepsy
Y N	Kidney/Liver Problems
Y N	History of Scarlet Fever
Y N	Handicaps/Disabilities
Y N	Environmental Allergies
Y N	Allergies to Medication

Other:

HABITS

Y N	Thumb/Finger Sucking
Y N	Lip Sucking/Biting
Y N	Nursing/Bottle Habits
Y N	Pacifier Habit
Y N	Nail Biting

MEDICAL INFORMATION

Describe the overall health of the child: Good ___ Fair ___ Poor ___

List medications child is currently taking: _____

List allergies to medication: _____

Describe any operations: _____

Describe any hospitalization(s): _____

Physician's Name: _____

Phone# () _____

City: _____

DENTAL INFORMATION

Y N	Does the child brush daily? If not, how often?
Y N	Does the child floss daily? If not, how often?
Y N	Is the child's water fluoridated?
Y N	Does the child take fluoridated supplements?
Y N	Has the child ever had pain/tenderness in the jaw joint? (TMJ)

PARENTAL CONSENT

I confirm that the information that I have given is true and correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my child's medical status, dental insurance, address, and/or phone number change. I also authorize Dr. Sharif and her dental staff to perform the necessary dental services that my child may need.

Sign: _____ Date: _____

DOCTOR NOTES

STAFF NOTES

I verbally reviewed the medical/dental information above with the parent/guardian & patient herein.
 Signature: _____ Date: _____
 Comments: _____

OFFICE USE ONLY

Medical History Update: _____
 *Date: _____ Signature: _____
 Note: _____
 *Date: _____ Signature: _____
 Notes: _____