Anjum S. Kherani, DMD
iSmile Kids
111 Broadway – Suite 1701
New York, NY 10006
212-267-0029

Date_____

PERSONAL HISTORY

Child's Information

Child's Name: _____
Address_____ Phone_____
Birth Date_____ Child's Age_____ Nickname (If any)_____
School_____ Grade_____

Names & Ages of Siblings _____
Interests, Hobbies, Pets, Favorite T.V. Shows, etc. _____
Person Responsible For This Account_____
Referred by:_____

Father's Information

Father's Name: _____
Home Address_____ City_____ Zip_____
Father's Phone (Home)_____ (Cell)_____
Father's Email Address:_____
Father's Occupation _____
Business Address_____ City_____ Zip_____
Father's Business Phone_____

Mother's Information

Mother's Name: _____
Home Address_____ City_____ Zip_____
Mother's Phone (Home)_____ (Cell)_____
Mother's Email Address:_____
Mother's Occupation _____
Business Address_____ City_____ Zip_____
Mother's Business Phone_____

MEDICAL HISTORY

Child's Physician or Pediatrician_____
Address_____ Phone_____
Date of last physical examination? _____
Is a physician treating your child now for a specific illness?..... Yes No
If so, for what reason? _____
Is your child taking medication at this time? (including over-the counter medications, vitamins, herbal supplements) …… Yes No

Medication	Dose	Frequency	Reason

Has your child shown any allergies or unusual reactions? (If yes, please describe)
a) Medications or drugs_____
b) Foods _____
c) Other_____
Has your child ever been hospitalized? …… Yes No
When _____ Reason_____
Has your child had any operations? …….. Yes No
When _____ Reason_____

Does your child have any history of the following diseases or conditions? (Please check if yes)

☐ Autism	☐ Blood Transfusions	☐ Liver Problems, Jaundice, or Hepatitis
☐ Attention deficit	☐ Cerebral Palsy	☐ Malignancies
☐ Accidents or Severe Infections	☐ Convulsion, Seizures, or Epilepsy	☐ Mental Retardation
☐ AIDS or AIDS related symptoms, HIV+	☐ Diabetes	☐ Psychological or Emotional Concerns
☐ Anemia or Blood Disorders	☐ Heart Murmur, Congenital Heart Disease	☐ Speech, Learning, or Hearing Disorders
☐ Asthma or Lung Problems	☐ Hyperactivity	☐ Vision Problems
☐ Bleeding Problems	☐ Kidney or Bladder Problems	☐ Headaches

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information the dentist should be aware or that has not been covered above.

DENTAL HISTORY

What is the reason for this visit today? _____
Is this your child's first visit to a dentist? …… Yes No
a) If not, how long since the last dental visit? _____
b) Child's previous dentist name:_____
Address: _____
c) Approximate date of last dental x-rays/films _____
Has your child ever had any unpleasant dental experience? …… Yes No
a) If so, please explain_____
Does he/she brush on his/her own or does an adult help with brushing? _____
a) How frequently are they brushed? _____
b) What time of the day are they brushed? _____
c) Does the patient eat after brushing at night?_____
d) What type of toothpaste does the patient use? Does it contain fluoride? _____
Do you or your child use dental floss in cleaning your child's teeth? …… Yes No
a) How frequently is flossing completed? _____
b) What time of the day is flossing completed? _____
Has your child had fluoride in any of the following forms?
a) Fluoride tablet or in multi-vitamin ……Don't Know Yes No
b) Drinking water at home (community fluoridation)……Don't Know Yes No
c) Drinking water at school ……Don't Know Yes No
Have your child's teeth ever been injured? ..... Yes No
a) When? _____
b) Which teeth? _____
c) Cause? _____
d) Were the teeth treated? …… Yes No
a. If so, describe treatment _____
What does the patient like to eat as a snack? _____
a) Does he/she eat fruit snacks, fruit roll-ups, and/or sticky candies? …… Yes No
What does the patient drink during meals? _____
What does the patient drink between meals? _____
Does the patient mainly drink tap water or bottled water? _____
What type of cup does the patient use to drink liquids (bottle, sippy cup, or regular cup)? _____

Has your child had any of the following habits:

			Date of Occurrence	How did the habit stop?
Bottle to bed at night or nap	☐ Yes	☐ No	_____	_____
Pacifier Use	☐ Yes	☐ No	_____	_____
Thumb or Finger Sucking	☐ Yes	☐ No	_____	_____
Tongue Thrusting	☐ Yes	☐ No	_____	_____
Lip sucking or Biting	☐ Yes	☐ No	_____	_____
Mouth Breathing	☐ Yes	☐ No	_____	_____
Grinds Teeth	☐ Yes	☐ No	_____	_____

Signature: _____ **Relationship:** _____