LAJI JAMES, D.D.S.

12121 Richmond Ave., Suite 326 - Houston, TX 77082

PERSONAL INFORMATION

CHILD'S NAME _____ DATE OF BIRTH _____ GENDER _____ AGE _____

BROTHERS _____ SISTERS _____

HOME ADDRESS _____ CITY _____ ZIP _____

HOME PHONE _____ MOM CELL PHONE _____ DAD CELL PHONE _____

EMAIL ADDRESS _____

WOULD YOU LIKE TO RECEIVE E-MAIL OR TEXT MESSAGE CONFIRMATIONS? EMAIL YES NO TEXT YES NO

MOTHER'S NAME _____ BIRTHDATE _____ SOCIAL SEC.# _____

MOTHER'S EMPLOYER _____ OCCUPATION _____ PHONE _____

MOTHER'S INSURANCE CO. _____ GROUP# _____ PHONE _____

FATHER'S NAME _____ BIRTHDATE _____ SOCIAL SEC.# _____

FATHER'S EMPLOYER _____ OCCUPATION _____ PHONE _____

FATHER'S INSURANCE CO. _____ GROUP# _____ PHONE _____

WHO DOES THE CHILD LIVE WITH? _____

PERSON WHO REFERRED YOU TO OUR OFFICE _____

WHICH SCHOOL DOES YOUR CHILD ATTEND? _____

MEDICAL HISTORY

IS YOUR CHILD IN GENERAL GOOD HEALTH? YES NO IF NO, PLEASE EXPLAIN _____

IS YOUR CHILD CURRENTLY BEING TREATED BY A PHYSICIAN? YES NO IF YES, PLEASE EXPLAIN _____

IS YOUR CHILD CURRENTLY TAKING ANY MEDICATION? YES NO IF YES, PLEASE LIST _____

HAS YOUR CHILD EXPERIENCED AN UNFAVORABLE REACTION OR ALLERGY TO DRUGS, INCLUDING ANTIBIOTICS (PENICILLIN) OR LOCAL ANESTHETIC (LIDOCAINE)?
YES NO IF YES, PLEASE EXPLAIN _____

HAS YOUR CHILD HAD ANY HISTORY OF PROBLEMS WITH THE FOLLOWING (PLEASE CIRCLE APPROPRIATE RESPONSE)

DEVELOPMENTAL DELAY	YES NO	ASTHMA	YES NO	BLEEDING OR BLOOD DISORDERS	YES NO
SPEECH DELAY/HEARING DIFFICULTY	YES NO	SEIZURES/EPILEPSY	YES NO	KIDNEY	YES NO
FREQUENT EAR/THROAT INFECTIONS	YES NO	ACID REFLUX	YES NO	LIVER/HEPATITIS	YES NO
FREQUENT FEVERS	YES NO	HEART	YES NO	DIABETES	YES NO
ALLERGIES	YES NO	CEREBRAL PALSY	YES NO	THYROID	YES NO
CHRONIC SINUS	YES NO	CANCER	YES NO	TUBERCULOSIS	YES NO

WHO IS YOUR CHILD'S PHYSICIAN? _____ PHONE _____

DENTAL HISTORY

LAST VISIT TO A DENTIST (DATE) _____ DENTIST'S NAME _____

HAS YOUR CHILD COMPLAINED ABOUT DENTAL PROBLEMS? YES NO IF YES, PLEASE EXPLAIN _____

HISTORY OF INJURIES TO MOUTH, TEETH, HEAD? YES NO IF YES, PLEASE EXPLAIN _____

HAS YOUR CHILD ANY HISTORY OF: (CIRCLE ALL APPROPRIATE RESPONSES)

THUMBSUCKING FINGERSUCKING LIP BITING NAIL BITING PACIFIER USE

AGE YOUR CHILD STOPPED BREASTFEEDING _____ BOTTLE FEEDING _____

DOES YOUR CHILD BRUSH TEETH DAILY? YES NO NUMBER OF BRUSHINGS _____ FLOSS DAILY? YES NO

DO YOU (PARENT OR OTHER ADULT) ASSIST YOUR CHILD WITH BRUSHINGS? YES NO FLOSSINGS? YES NO

IS FLUORIDE TAKEN IN ANY FORM? YES NO _____

DO YOU EXPECT YOUR CHILD TO COOPERATE FOR EXAMINATION, CLEANING, DENTAL TREATMENT? YES NO

IF NO, PLEASE EXPLAIN _____

FINANCIAL ARRANGEMENTS

Payment for dental treatment is expected when services are performed. We accept cash, check, MasterCard, Visa and Discover. If you have dental insurance, you must provide us with all information required and we must have time to verify with your insurance company in order to file insurance for that appointment. ***The full fee is still the parent's responsibility if the insurance does not cover the procedure for whatever reason.***

Signature _____ Date _____

CONSENT FOR TREATMENT

State law requires us to obtain your written consent for dental treatment or surgery. Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain it.

I hereby authorize Laji J. James, D.D.S. assisted by other dentists and/or dental auxiliaries of their choice to perform upon my child or legal ward dental treatment or oral surgery procedures including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnosis aids.

X _____ Examination, cleaning of teeth and application of topical fluoride.

_____ Application of plastic sealants to the grooves of the teeth

Treatment of diseased (decayed) or injured teeth with dental restorations (fillings or crowns).

Treatment of diseased or injured tissues (hard and/or soft), including nerve treatment(s).

Extraction (removal) of one or more teeth

Replacement of missing teeth with false teeth.

Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities.

_____ Use of sedative drugs to control pain, gagging, apprehension and/or disruptive behavior.

_____ Use of physical restraint or restraining devices to help safely accomplish the necessary dental procedure without the use of deep sedation or general anesthesia

_____ Use of ***general anesthesia*** to accomplish the necessary treatment

Other _____

I understand that although good results are expected, the possibility and nature of complications cannot be accurately anticipated and therefore, no guarantee is expressed or implied either as to result of the treatment or as to cure. I further authorize the doctor to perform other dental service(s) that in his/her judgment are advisable for my child or legal ward, with the exception of (if none, state so):

_____ NONE _____

_____

Although their occurrence is extremely rare, some risks have been reported to be associated with dental or oral surgery procedures. State law requires us to mention the possible risk of numbness, infection, swelling, bleeding, pain, bruising, discoloration, nausea, vomiting, allergic or drug reactions, brain damage, stroke, heart attack, aspiration or swallowing of a foreign object, or scars associated with such procedures. I further understand and accept that very unusual complications may require hospitalization and may even result in death.

I hereby state that I have read and understand this consent, and that all questions I have were answered to my satisfaction. I understand I have the right to be provided with answers to questions which may arise during the course of my child's treatment.

I understand that this consent will remain in effect until such time that I choose to terminate it in writing.

I have received a copy of this consent if I requested one.

X Signature of Parent _____

Signature of Dentist/Staff _____ Date _____

Acknowledgement of Receipt
Notice of Privacy Practices

By signing below I acknowledge that I have received or reviewed the Notice of Privacy. I agree with the terms of this notice and understand my rights under this notice. **By signing below I consent for the use of my personal health information for treatment, payment, and operations and other uses as described in the privacy notice**. I also understand that I have the right not to sign this agreement.

Name:_____

Signature:_____

Relationship to Patient:_____

Date:_____

If we are unable to get your acknowledgement then our office will make a notation as to the reason why it was not obtained.

Reason why acknowledgement was not obtained:

_____
_____
_____

Staff Name:_____

Signature: _____

Date:_____
