LAJI J. 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: _____

PRESCRIBED FOR WHAT CONDITION? _____

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

_____

HAS YOUR CHILD 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	RHEUMATIC FEVER	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 TOOTH BRUSHINGS? YES NO FLOSSINGS? YES NO

PURPOSE OF DENTAL VISIT TODAY: _____

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 as specified below:

X_____ Examination

_____ Cleaning of the teeth

_____ Dental X-rays

_____ Application of Fluoride

_____ 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 services(s) that in her/his 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 have requested one.

X_____

SIGNATURE OF PARENT

_____ _____

SIGNATURE OF DENTIST / STAFF DATE