

tel. 415.459.1444 • fax 415.453.1320
www.openbigdds.com



MARTIN SINAI RAYMAN, D.D.S.

MARY C. LE, D.D.S., M.S.

Dentistry for infants, children and adolescents.

Diplomates, American Board of Pediatric Dentistry
912 Grand Avenue #202, San Rafael, CA 94901-3552

a pediatric dental practice built on experience - constantly progressing through innovation and enthusiasm

GET ACQUAINTED QUESTIONNAIRE

CHILD'S Complete Name			Nickname	
Sex	Age	Birthdate	Home Tel.	Cell
Home Address			City	Zip Code
Person responsible for this account:		Mother	Father	Other

FATHER'S Name	Occupation	Soc. Sec. No.		
Home Address	City	Zip	How Long	Tel.
Name of Employer	Bus. Address		Cell	
Business Telephone	How long with current business		Email	

MOTHER'S Name	Occupation	Soc. Sec. No.		
Home Address	City	Zip	How Long	Tel.
Name of Employer	Bus. Address		Cell	
Business Telephone	How long with current business		Email	

Do mother, father and child live together? Yes No If no, please explain:

Names, ages of siblings

Do you have a dental insurance plan? Yes No Dual? Yes No

FATHER	MOTHER
1. Name of employee covered under this plan	1. Name of employee covered under this plan
2. Soc. Sec. No.	2. Soc. Sec. No.
3. Name and Address of Insurance Co.	3. Name and Address of Insurance Co.
4. Group or Policy No.	4. Group or Policy No.
5. Employee's birthdate	5. Employee's birthdate

I hereby authorize direct payment (of the group insurance benefits otherwise payable to me) to Martin Rayman, D.D.S.

(Signed, Insured person)

I hereby authorize direct payment (of the group insurance benefits otherwise payable to me) to Martin Rayman, D.D.S.

(Signed, Insured person)

Name of former dentist, if any	Telephone
Address	Date of last dental care
Whom may we thank for referring you to our office?	
Address	Telephone
Name of parents' dentist(s)	

PERMISSION FOR DENTAL TREATMENT

I hereby give permission to MARTIN S. RAYMAN, D.D.S., and/or MARY C. LE, D.D.S., M.S. to render all necessary dental services and to use such methods and agents as he or she sees fit for the child named on this form and to contact the child's physician as necessary. I understand that no treatment will be started until the recommended treatment, time involved and financial investment have been discussed with me by either Dr. Rayman, Dr. Le, or one of the staff members, at which time I may void this permission if I so choose. I will be responsible for any bills incurred by this child for dental treatment.

Date _____ Signed (Parent or Guardian) _____

PLEASE TURN OVER TO FILL OUT OTHER SIDE

HEALTH HISTORY

This information can be of great value to better understand your child.

MEDICAL

1. Family Physician or Pediatrician (If Kaiser, include patient number):

Address:

Telephone:

2. Is your child:

In good general health right now? Yes No

If NO, please explain:

Sensitive or allergic to any drug including penicillin or local anesthetic? Yes No

At present taking any drugs? Yes No List:

Allergic to food, animals, latex, dust? Yes No Other:

3. Has your child ever been hospitalized? Yes No If yes, for what?

4. Any history or difficulty with any of the following: anemia, asthma, bone disorders, brain injury, excessive bleeding, convulsions, cerebral palsy, diabetes, epilepsy, fainting or dizziness, hearing, hepatitis, heart trouble, cancer or malignancies, rheumatic fever, or premature birth or intubated? Yes No

If yes please circle above and explain in more detail:

5. Are there any learning problems?

Please describe:

6. How would you expect your child to behave in our office?

Please describe:

7. Would you describe your child as (please circle) shy, frightened, apprehensive, outgoing?

8. Is there something special you'd like us to know about your child and/or family?

DENTAL

1. Is this an emergency visit?

Please describe:

2. Is this the first visit to the dentist?

3. Has any member of your family previously been a patient of this office?

Names and ages:

4. Present dental problem as you see it (if any):

5. Has your child complained about dental problems?

Please describe:

6. Has your child had any unhappy experiences with dental care?

7. Is your child's attitude towards dentistry good?

8. Any mouth habits: thumb sucking, pacifier, nail biting, finger sucking, grinding?

9. Has your child had any history of cavities, toothaches, pain, broken teeth, extracted teeth, gum infections, missing permanent teeth or extra permanent teeth?

If yes, please circle condition(s) above.

10. Has your child ever had an injury to the head, mouth or teeth?

Describe:

11. First tooth erupted at about how many months old?

12. At what age was your child weaned from the breast or bottle?

13. Name your child's favorite toy, hobby, TV show, etc.

14. School attends:

15. When and how often does your child brush?

16. Do you assist your child with brushing? Yes No

17. How often is dental floss used?

18. Is fluoride taken? If yes, circle all that apply: drops tablets vitamins toothpaste gel

19. Have mother and/or father had much tooth decay? Yes No

20. Has either parent had difficulty getting numb for dental treatment? Yes No

21. Do you use tap, filtered or bottled water for cooking and/or drinking? Circle all that apply.

Reviewer's Initials _____

Date _____