NYACK
PEDIATRIC DENTISTRY

PATIENT INFORMATION

Child's Name____ Date ______________

Home Address____Phone ______________

Sex [ ] M [ ] F Age _________ Birth Date _____________ Nickname ______________________________________

Names and Ages of Brothers and Sisters ____

Hobbies, Pets, Favorite TV Shows, etc. ____

Person Responsible for this Account ___________________________________ Email ________________________

Whom may we thank for referring you? ____

DENTAL HISTORY

Reason for this visit (1st examination, check-up, toothache, etc.) ____

____

Has your child ever had an injury to the mouth, teeth or jaws (fall, blow, etc.)? ________________________________

How long since last visit to a dentist? ____

Was the dental experience pleasant or unpleasant? ____

If unpleasant, how did he/she react? ____

Did he/she object to anything in particular? ____

Does your child have any history of thumb or lip sucking, pacifier, nail or lip biting? If yes, please explain:

____

Does your child use fluoride toothpaste? ___________

Has your child ever taken fluoride supplements or vitamins with fluoride? __________

MEDICAL HISTORY

Child's physician/pediatrician___________________________________ City___________ Phone_______________

Is your child in good health? ________ Is your child taking any medications? _________________________________

Is your child allergic to any medications? __________________________ General allergies? ____________________

Any history of cerebral palsy, seizures, fainting, or loss of consciousness?	No	Yes
Any sensory disorders? (Seeing, Hearing, Sensory Integration Disorder)	No	Yes
Has your child been diagnosed with PDD, autism, ADHD or ADD?	No	Yes
Any history of congenital heart disease, heart murmur or rheumatic fever?	No	Yes
Has any heart surgery been done or recommended?	No	Yes
Has your child ever had a blood transfusion?	No	Yes
Any history of anemia or sickle cell disease?	No	Yes
Does your child bruise easily or bleed excessively from small cuts?	No	Yes
Any history of pneumonia, cystic fibrosis, asthma, or difficulty breathing?	No	Yes
Any history of stomach, intestinal, kidney or liver problems?	No	Yes
Any history of hepatitis?	No	Yes
Any history of diabetes?	No	Yes
Any history of thyroid disease or other glandular disorders?	No	Yes
Has your child ever been hospitalized?	No	Yes
(If yes, please explain) ____		
Is your child up to date with immunizations? (DPT,IPV,MMR,Hib,HepB)	No	Yes

Any additional or related problems?____

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INSURANCE

Father's/Guardian Name:	Mother's/Guardian Name:
Address (if different from Patient's):	Address (if different from Patient's):
Home Phone_____________ Work Phone_____________	Home Phone_____________ Work Phone_____________
Employer:	Employer:
Soc Sec# ________________ Birthdate _______________	Soc Sec# ________________ Birthdate _______________
Do you have dental insurance for minor Child? Yes No	Do you have dental insurance for minor Child? Yes No
Plan Name:	Plan Name:
Plan Phone Number:	Plan Phone Number:
Plan Address:	Plan Address:
Plan Group Number:	Plan Group Number:
Plan Policy Number:	Plan Policy Number:

CONSENT:

1. The undersigned hereby authorizes the doctor to take radiographs, study models, photographs, or any other diagnostic aids deemed appropriate by the doctor for a thorough diagnosis of the patient's dental needs.
2. I also authorize the doctor to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment in connection with (name of patient)____________________________________. I understand that using anesthetic agents embodies a certain risk. Furthermore, I authorize and consent that the doctor choose and employ such assistance as deemed fit to provide recommended treatment.
3. To the best of my knowledge, the above information is complete and accurate. I understand that even though I may have some type of dental insurance coverage, I am responsible for payment services rendered. I authorize release of any information to my insurance company related to my dental claims.

Parent/Guardian Signature Date   Dentist Signature Date

DENTIST'S COMMENTS:

Medical consultation recommended? No____ Yes ____ Date Requested ___________________________________

Purpose for consultation:____

SEMIANNUAL REVIEW OF MEDICAL-DENTAL HISTORY: If history remains essentially unchanged, sign below:

Parent/Guardian Signature Date   Dentist Signature Date

Parent/Guardian Signature Date   Dentist Signature Date

Parent/Guardian Signature Date   Dentist Signature Date