PATIENT INFORMATION

Date _____

Patient's Name _____ Nickname _____

Age _____ Birth date _____ Sex M [ ] F [ ] School _____

Parent 1 Name _____ Cell Phone _____

Birth date & SS# _____

Parent 2 Name _____ Cell Phone _____

Birth date & SS# _____

Home Address _____

Email _____ Home Phone _____

Siblings Names and Ages _____

Nanny's Name _____ Cell Phone _____

Does your nanny have your permission to consent to dental treatment for your child in your absence? Yes [ ] No [ ] Comment _____

Child's Physician _____ Phone # _____

Pharmacy _____ Phone # _____

Whom may we thank for referring you? _____

PAYMENT IS DUE IN FULL AT TIME OF TREATMENT

Person responsible for child's financial support _____

DENTAL INSURANCE

Dental Coverage Yes [ ] No [ ]

Insured's Name: _____ Relation: _____

Insured's Birth date: _____ Employer: _____

Insurance Co. Name: _____ Phone #: _____

Insurance Co. Address: _____

Member ID: _____ Group #: _____

HISTORY

Reason for this visit _____

1. Is a physician treating your child at this time? Yes [ ] No [ ]
2. Date of child's last physical _____
3. Has your child ever been a patient in a hospital? Yes [ ] No [ ]
4. Has your child received general anesthesia or sedation? Yes [ ] No [ ]
5. Does your child have allergies? (Medicine, Food) Yes [ ] No [ ]
6. Is your child taking any medication at this time? Yes [ ] No [ ]
   If yes, what? _____
7. Has your child ever had a blood transfusion? Yes [ ] No [ ]
8. Does your child smoke or use tobacco products? Yes [ ] No [ ]
9. Has a dentist before ever seen your child? Yes [ ] No [ ]
   Date last seen?_____ Name of Dentist _____
10. Has your child ever received fluoride in any form? Yes [ ] No [ ]
11. Does your child suck his/her thumb or fingers? Yes [ ] No [ ]
12. Are your child's teeth brushed once or more a day? Yes [ ] No [ ]
13. At what age did your child stop bottle/breast feeding? Yes [ ] No [ ]

Has this child ever had any treatment for any of the following?
Blood-Circulatory [ ] Gastrointestinal (stomach) [ ] Muscles [ ] Bones [ ]
Kidney-Bladder [ ] Nervous System [ ] Endocrine Glands [ ] Heart [ ] Skin [ ] Liver [ ]
Ears, Eyes, Nose, Throat [ ] Tonsils/Adenoids [ ]
This child has NOT had any treatment for the above _____

Has this child ever been diagnosed as having the following conditions?
AIDS [ ] Anemia [ ] Allergy [ ] Arthritis [ ] Asthma [ ] Autism [ ] Brain Injury [ ]
Bronchitis [ ] Cancer [ ] Cerebral Palsy [ ] Chicken Pox [ ] Cleft Lip/Plate [ ]
Convulsions/Seizures [ ] Diabetes [ ] Diphtheria [ ] Drug/Alcohol Abuse [ ] Epilepsy [ ]
Eye Problems [ ] Excessive Bleeding Problem [ ] Fainting [ ] Hearing Loss [ ]
Heart Disease [ ] Hemophilia [ ] Hepatitis Type A/B [ ] Jaundice [ ] Leukemia [ ]
Measles [ ] Mental Retardation [ ] Mumps [ ] Mouth Breathing [ ]
Nutritional Deficiency [ ] Venereal Disease [ ] Whooping Cough [ ]
This child has never been diagnosed as having any of the above conditions_____

Is the anything else that you think we should know about your child?

_____

I certify that I have read and understand the above questions. I will not hold Dr. Lodolini, Dr. Bianchi, Dr. Greenberg, or any member of their staff; responsible for any errors or omissions I may have made in the completion of this form.

_____ _____ _____

Signature of person completing form Relationship to patient Date