PEDIATRIC DENTISTS NYC

Child's Registration and History

Patient Information

Today's Date _____

Child's Name _____

Nickname _____

Gender _____

Date of Birth _____

Home Address _____

_____

School _____

Grade _____

SSN _____

Who is accompanying the child today?

Name _____

Relation _____

Whom may we thank for referring you?

Name _____

Other family members seen by us _____

Previous or present dentist _____

Date of last visit to a dentist _____

For what service _____

Do you have dental insurance? ☐ Yes ☐ No

Name of Carrier _____

Policy # _____

Group# _____

Child's Name _____

First Parent Name _____

Home Number _____

Cell Number _____

Email _____

Employer _____

Work # _____

Date of Birth _____

If Applicable: ☐ Step Parent ☐ Legal Guardian

Other: _____

Second Parent Name _____

Home Number _____

Cell Number _____

Email _____

Employer _____

Work # _____

Date of Birth _____

If Applicable: ☐ Step Parent ☐ Legal Guardian

Other _____

Parent's Marital Status

☐ Single ☐ Married ☐ Widowed

☐ Divorced ☐ Separated ☐ Partners

PEDIATRIC DENTISTS NYC

Child's Registration and History

Child's Name _____

Medical History

Child's Physician _____

Phone # _____

Address _____

_____

Date of last Examination _____

Is your child currently under the care of a physician?

☐ No ☐ Yes - If "Yes", for what (other than routine examinations)? _____

_____

Please describe the child's current physical health:

_____

_____

Please discuss any medical conditions hat the child has:

_____

_____

_____

Please list all medication that the child is currently taking:

_____

_____

_____

Please list all medication that the child is allergic to:

_____

_____

_____

Are there any other allergies: food, pollen, animals, dust...

_____

_____

Has the child ever had any of the following medical problems? Check all that apply.

- ☐ Heart murmur
- ☐ Congenital heart defect
- ☐ Kidney/Liver problems
- ☐ Hemophilia
- ☐ Abnormal Bleeding
- ☐ Anemia
- ☐ Fainting
- ☐ Thyroid problems
- ☐ Mastoid problems
- ☐ Diabetes
- ☐ Cancer
- ☐ Mononucleosis
- ☐ Convulsions/Epilepsy
- ☐ Rheumatic fever
- ☐ HIV+/AIDS
- ☐ Hepatitis
- ☐ Tuberculosis
- ☐ Asthma/Chronic sinus
- ☐ Chicken pox
- ☐ Measles
- ☐ Mumps
- ☐ Handicap/disabilities
- ☐ Hearing impairment
- ☐ Any injuries to the head
- ☐ Operations
- ☐ Any stays in the hospital
- ☐ If "Yes", why? _____

_____

PEDIATRIC DENTISTS NYC

Child's Registration and History

Child's Name _____

Dental History

Are there problems associated with previous dental work?

☐ Yes ☐ No

Is the child's water fluoridated?

☐ Yes ☐ No

Is the child taking fluoride supplements?

☐ Yes ☐ No

Does the child brush their teeth daily?

☐ Yes ☐ No

Do you, or someone else, assist with brushing?

☐ Yes ☐ No

Floss their teeth daily?

☐ Yes ☐ No

Are there any unusual speech problems?

☐ Yes ☐ No

Do you desire complete dental service for the child (exam, cleaning and x-rays if needed)?

☐ Yes ☐ No

May we request your child's medical/dental records for our reference?

☐ Yes ☐ No

Does the child have any of the following habits?

Check all that apply.

- ☐ Nursing / Bottle Habits
- ☐ Pacifier
- ☐ Thumb / Finger Sucking
- ☐ Lip Sucking / Biting
- ☐ Nail Biting/ Cheek Biting
- ☐ Other _____

Why did you bring your child to the dentist today?

_____

_____

The Parent of Guardian who accompanies the child is responsible for the payment at the time of services in the form of check, cash, or credit card unless prior arrangements are made. I understand that the information given is correct to the best of my knowledge, that it is confidential and it my responsibility to notify the office of any changes in the information given in this form.

_____ _____

Signature Date

_____

Relation to Child

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.