Suffolk Pediatric Dentistry and Orthodontics

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www.SuffolkPediatricDentistry.com

WELCOME

We are pleased to welcome you and your child to our practice.
Please take a few minutes to fill out this form as completely as you can.

PATIENT INFORMATION

Date ____________ SS/HIC/Patient ID # ____________ Birthdate ____________

Name of Minor/Child ____________ (Last Name, First Name, Middle Initial) Sex ☐ M ☐ F Age ______

Nickname ____________ Hobbies ____________ Cell Phone ( ) ____________

Home Address ____________ (Street, City, State, Zip)

Mailing Address ____________ (Street, City, State, Zip)

School Name ____________ School Phone ( ) ____________

Person financially responsible ____________ Home Phone ( ) ____________ Work Phone ( ) ____________

Whom may we thank for referring you? ____________ Phone # ( ) ____________

INSURANCE

Father's/Guardian's Name ____________

Address (if different from patient's) ____________

Home # ( ) ______ (If different from above) Work # ( ) ______ (If different from above)

E-mail ____________

Employer ____________

Soc. Sec. # ____________ Birthdate ____________

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name ____________ Phone ( ) ____________

Address ____________

Group# ____________ Policy # ____________

Mother's/Guardian's Name ____________

Address (if different from patient's) ____________

Home #( ) ______ (If different from above) Work #( ) ______ (If different from above)

E-mail ____________

Employer ____________

Soc. Sec. # ____________ Birthdate ____________

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name ____________ Phone ( ) ____________

Address ____________

Group # ____________ Policy # ____________

DENTAL HISTORY

Date of last visit to a dentist ____________ For what service? ____________

	Yes	No
Has child complained about dental problems?	☐	☐
Does child brush teeth daily?	☐	☐
Does child use floss every day?	☐	☐
Any learning problems?	☐	☐
Is fluoride taken in any form?	☐	☐
Any injuries to mouth, teeth, head?	☐	☐
Any unhappy dental experiences?	☐	☐
Any school problems?	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?	☐	☐

MEDICAL HISTORY

Pediatrician ______________________ Address & Phone# ______________________

	Yes	No
Is Minor/Child under care of physician now?	☐	☐
Receiving any medication or drugs?	☐	☐
Ever been hospitalized?	☐	☐
Ever had surgery?	☐	☐
Is there excessive bleeding when cut?	☐	☐

Medications ______________________

Allergies ______________________

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✓)

☐ A.I.D.S./H.I.V.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

ATTENTION BEHAVIOR

☐ ADHD ☐ ADD ☐ PDD ☐ HYPERACTIVITY ☐ OTHER

☐ Autism Spectrum ☐ Sensory Issues ☐ Social Issues

EMERGENCY CONTACT

IN CASE OF EMEREGNCY, WHO SHOULD WE CONTACT?

Name: ______________________ Relationship: __________ Phone __________

AUTHORIZATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of ______________________
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with ______________________
Name of Insurance Company (ies)

and assign directly to Dr. ______________________ all insurance benefits, if any,

otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named insurance Company (ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. I have reviewed the offices "Notice of Privacy Practice" policy.

______________________ Signature of Parent, Guardian or Personal Representative ______________ Date

______________________ Please Print Name of Parent, Guardian or Personal Representative ______________ Relationship to Patient

UPDATE

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe ______________________

Is patient taking any new medications? ☐ Yes ☐ No If yes, please list ______________________

Date __________ Parent/Guardian Signature ______________________

Date __________ Dentist Signature ______________________