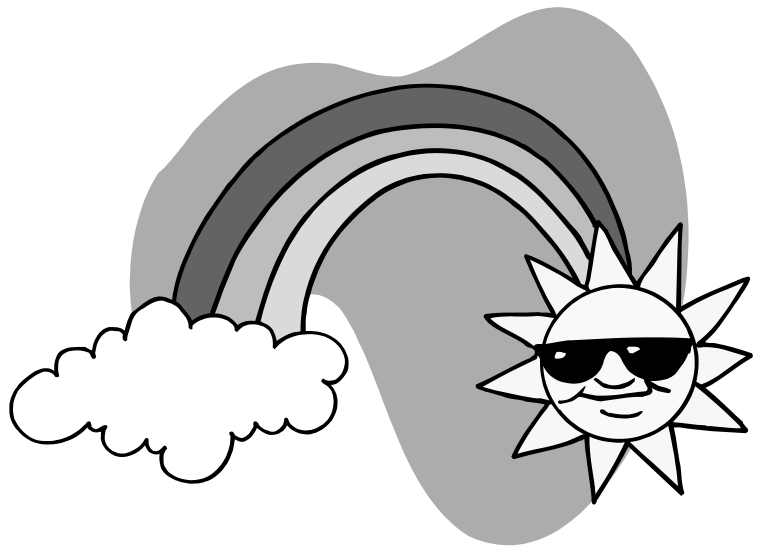


7 Harker Avenue • Suite One
Berlin, New Jersey 08009

The benefits of a happy healthy smile are immeasurable! Our goal is to help you reach and maintain maximum oral health.

Please fill out these forms completely. The better we communicate, the better we can care for you.



1

Tell Us About Your Child

Today's Date: _____

Child's Name: _____

Nickname: _____ Male Female

Child's Birthdate: ____ / ____ / ____ Child's Age: _____

School: _____ Grade: _____

Child's Home #: _____ SS #: _____

Child's Home Address: _____

3

Has the child ever had the following medical problems?

- | | |
|---------------------|-----------------------------|
| Y N Heart Murmur | Y N Congenital Heart Defect |
| Y N Cancer | Y N Seizures/Epilepsy |
| Y N Diabetes | Y N Abnormal Bleeding |
| Y N Rheumatic Fever | Y N Hearing Impairment |
| Y N HIV+/AIDS | Y N Any Operations |
| Y N Hemophilia | Y N Any stays in hospital |
| Y N Asthma | Y N Kidney/Liver Problems |
| Y N Hepatitis | Y N Handicaps/Disabilities |
| Y N Tuberculosis | Y N Allergies to any drugs |

Please discuss any medical problems that the child has had:

2

Why did you bring the child to the dentist today?

Has the child ever had a serious/difficult problem associated with previous dental work? Yes No

Is the child taking fluoridated supplement? Yes No

Has the child ever had any pain/tenderness in their jaw joint (TMJ/TMD)? Yes No

Relationship to patient: _____

How often does the child brush their teeth: _____

Do they floss their teeth? Yes No

Does the child receive assistance when brushing? Yes No

Child's Physician: _____

Physician Phone #: _____ Last Visit Date: _____

Is the child currently under the care of a physician? Yes No

Describe the child's current health: Good Fair Poor

Please list all drugs that the child is currently taking:

Please list all drugs/latex that the child is allergic to:

4

Does the child have the following habits?

- | |
|--------------------------|
| Y N Thumb/Finger Sucking |
| Y N Lip Sucking/Biting |
| Y N Nail Biting |
| Y N Pacifier Habit |

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

5

Who is accompanying your child today?

Name: _____

Relation: _____

Do you have legal custody of the child? Yes No

Whom may we thank for referring you: _____

Other family members seen by us: _____

Previous/Present Dentist: _____

Last visit date: _____

Parent's Marital Status: Single Married Widowed Divorced Separated



7 Person Responsible for Account
Name: _____ **Relation:** _____
Billing Address: _____

Wk#: _____ **Ext:** _____
Hm#: _____ **Cell#:** _____
DL#: _____ **SS#:** _____
Who is responsible for making appointments?
Name: _____
Wk#: _____ **Ext:** _____
Hm#: _____ **Cell#:** _____

6 Mother's Information Step Mother Guardian
Name: _____
Wk#: _____ **Ext:** _____
Hm#: _____ **Cell#:** _____
Employer: _____
SS#: _____ **DL#:** _____
Father's Information Step Mother Guardian
Name: _____
Wk#: _____ **Ext:** _____
Hm#: _____ **Cell#:** _____
Employer: _____
SS#: _____ **DL#:** _____

8 Primary Dental Insurance
Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Phone #: _____
Group # (Plan, Local, or Policy #): _____
Insured's Name: _____
Relationship to patient: _____
Insured's Birthdate: ____ / ____ / ____ **SS#:** _____
Insured's Employer: _____
Orthodontic Coverage? Yes No
Secondary Dental Insurance
Insurance Co. Name: _____
Insurance Co. Address: _____
Insurance Phone #: _____
Group # (Plan, Local, or Policy #): _____
Insured's Name: _____
Relationship to patient: _____
Insured's Birthdate: ____ / ____ / ____ **SS#:** _____
Insured's Employer: _____
Orthodontic Coverage? Yes No

9 I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status.

I authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent or guardian **Date**

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

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I verbally reviewed the medical/dental information above with the parent/guardian & patient herein:
Initials: _____ **Date:** _____
Doctor's Comments: _____

Medical History Update
1. Date: _____ **Signature:** _____
Comments: _____

2. Date: _____ **Signature:** _____
Comments: _____

3. Date: _____ **Signature:** _____
Comments: _____
