Wantagh Seaford Pediatric Dentistry

Your Child's Name:_____

Nickname _____ Male___ Female___

Date of Birth: ____/____/____ Age ____

School:_____ Grade:_____
Child's **primary** address:_____
City/State_____Zip_____Tel:_____

Primary Insurance Carrier:_____
Secondary Insurance Carrier:_____

Parent/Legal Guardian #1:

Name: _____

SS#:_____Birthdate: ____/____/____
Occupation/Employer: _____
Work phone: _____Ext:_____
Phone: (home)_____(mobile)_____
Email: _____

Parent/Legal Guardian #2:

Name: _____

SS#:_____Birthdate: ____/____/____

Occupation/Employer: _____

Work phone: _____Ext:_____

Phone: (home)_____(mobile)_____

Email: _____

Parents' Marital Status (circle one):

Single Married Divorced Widowed Separated

Preferred contact for scheduling appointments: _____

Please list the names/ages of any other children you have at home: _____

_____

Who is accompanying the child today?

Name_____

Relationship to child_____

Do you have legal custody of this child? ___Yes___No

Person Responsible for Account:

Name: _____

Relationship to Child: _____
SS#:_____ Birthdate: ____/____/____

Billing Address (if different from child): _____

_____

Work phone: _____ Ext:_____

Phone: (home)_____(mobile)_____

Email: _____

Dental History:

Is this your child's first visit to the dentist? ____Yes ____ No

If not, name/location of previous dentist:_____

_____

Date of last exam: _____

Were previous x-rays taken? ____ If yes, when? _____

Has your child ever had a negative experience at the dentist?

_____ Yes _____ No

Does your child use Fluoride toothpaste?_____ Yes _____ No

How often does your child brush their teeth? _____

Do they get help or do they do it alone? _____

Does your child floss?_____ How often?_____

Please circle if your child has had any of the following problems?

Cavities/Fillings Toothache Gum Infections
Grinding/Clenching Sensitivity Jaw Discomfort

Oral Habits : Thumb Pacifier Fingers Lip

Other habits: _____

Has there ever been any injuries to your child's teeth, face or mouth? ____ Yes ____No
If Yes, Please explain : _____
_____

Do you have any concerns you would like the doctor to focus on at today's visit? _____
_____

3426-3428 Merrick Rd, Seaford NY 11783 Ph. 516.783.WSPD [9773] F. 516.783.9770

Wantagh Seaford Pediatric Dentistry

Health History:

Name of Pediatrician: _____

Address_____ Phone: _____

Current Medications:_____

_____

_____

Allergies: _____

_____

Past Surgeries:_____

_____

Any Implants/Shunts or metal objects (pins/rods):

_____

Hospital stays: _____

_____

Who may we thank for referring you to our office? _____

_____

Has your child ever had any of the following (please circle):

ADD/ADHD	Abnormal Bleeding	Acid Reflux
Anemia	Allergy to Drugs	Allergy to Latex
Anxiety	Asthma	Autism/Aspergers
Cancer	Cerebral Palsy	Bleeding problems
Depression	Cleft Lip/Palate	Congenital Birth Defects
Diabetes	Developmental	Chronic Infections
Heart Disease	Delays Epilepsy/	Handicaps/Disabilities
Heart Murmur	Seizures	Liver Disease
HIV+/AIDS	Hearing/Speech Impairment	Thyroid Disease
PDD	ODD	
Pregnancy	Physical Therapy	Liver Disease

Other:_____

_____

Please explain any medical problems your child has:

_____

_____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can put my child's health at risk. Furthermore, I understand that it is my responsibility to inform this dental office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services that my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such dental care to third party payors and/or other health practitioners as necessary. I hereby authorize the Doctors of Wantagh Seaford Pediatric Dentistry, PC to perform the examination and after explanation, any and all treatment for the above named child including radiographs if indicated and consent to such methods, drugs and agents that may be indicated in connection with his/her dental care. This consent shall remain in effect until canceled. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that, as a condition of my child's treatment by this office, financial arrangements must be made in advance.

Signature of parent/legal guardian _____ Date _____

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