Pediatric Dentistry of North Jersey_ smilecareforkids.com
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Welcome ! How did you choose our practice?_____
(person name, pediatrician, dentist, other)
Do we see other family members? _____

Patient's name: First_____Last_____Nickname_____
Date of Birth_____ ____Male ____Female Todays date_____
Address_____
Home phone _____ Cell phone_____Email_____
Who is accompanying the child today?_____

MEDICAL HISTORY

Child's Physician_____
name address phone
Child's general state of health ___Excellent ____Fair _____Poor
Date of last physical examination _____
Has your child been under a physicians care recently? _____Yes _____No
Reason_____
Has your child been hospitalized recently? _____Yes _____No
Reason_____
Has your child ever had a serious illness or operation? _____Yes _____No
If yes, please explain_____
Is your child now taking (or during last 6 months) any medications? _____Yes _____No
If yes, medicine_____ Reason_____
Does your child have any allergies? _____Yes _____No
If yes, to what?_____

Please check if your child has ever had any of the following.

___Heart Disease	____Heart Murmur	____Rheumatic fever
___Hepatitis	____Liver Disease	____Kidney Disease
___Diabetes	____Tuberculosis	____Bleeding Problems
___Asthma	____Lung Trouble	____Hearing/Speech Issues
___Anemia	____Blood Transfusions	____Epilepsy/Convulsions
___HIV+/ AIDS	____ADD/ADHD	____Autism
___Developmentally delayed		____Handicaps/Disabilities

Other important health issues_____

Has your child's physical development been normal? ____Yes _____No
If no, please explain_____
_____
Does your child have any emotional, neurological or learning issues? ___Yes _____No
If yes, please explain_____
_____

DENTAL HISTORY

Is this child's first dental visit? _____Yes _____No
Date of child's last visit to the dentist
_____
Dentist's Name _____ Phone/Address_____
Reason for last dental visit
_____
Were x rays taken? _____Yes ____No Do you have copies of them? _____Yes _____No
Was last dental experience positive? ____Yes ____No
If not, please explain_____
_____

Does your child have any history of:

___teeth extracted ___local anesthetic (novacaine) ____nerve treatment
___Orthodontics ___finger/thumb sucking ____tongue thrusting
___bottle nursing ___injury to teeth or face

Any other concerns about your child's teeth?
_____
_____
_____
How many children in your family? _____ Ages _____
Patient's favorite toys, hobbies, pets, TV shows, etc._____
_____

FAMILY INFORMATION

	Father	Mother
Name	_____	_____
Occupation	_____	_____
Employer	_____	_____
Work address	_____	_____
Date of Birth	_____	_____
Soc. Sec. #	_____	_____
Work phone	_____	_____
Dental Insurance Co.	_____	_____
Group/Policy #	_____	_____
Subscriber #	_____	_____
Ins. Address	_____	_____
Ins. Phone#	_____	_____

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. It is my responsibility to inform this office of any changes in my child's medical status. I authorize the doctors to perform the necessary dental services my child may need.

_____ _____ _____
Signature of Parent or Guardian Date Relationship to Patient

Additional Information _____
_____
_____