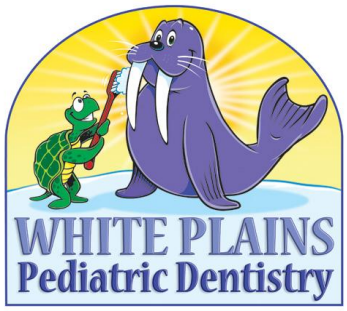

Larchmont Pediatric Dentistry

Child's name_____ Birth date_____ Sex: F M

Child's Social Security #_____ Name child goes by_____
Hobbies/Pets_____
Child's Home Address_____
City_____State_____ Zip_____ Phone #_____
School_____ Grade _____
Name and ages of other children in family_____
Names of other children already treated in our office_____
Do parents live together? ____Yes ____No If not, with whom does the child live? _____

Parent One: Relationship to Patient_____

Name_____ DOB _____ Occupation_____
Last/ First/ MI
Employer_____ Work Phone #_____
SS#_____ Pager# _____ Cell#_____
Marital Status_____ Email Address_____

Parent Two: Relationship to Patient_____

Name_____ DOB _____ Occupation_____
Last/ First/ MI
Employer_____ Work Phone #_____
SS#_____ Pager# _____ Cell#_____
Marital Status_____ Email Address_____

Where did you hear about our office? _____
Who may we thank for referring your child? Name: _____
Address: _____ Phone #: _____

In case we need to contact you and cannot do so with the provided information, please provide the following information for an alternative contact person in an emergency situation:

Name: _____ Relationship to your child: _____
Address: _____
Home Phone #: _____ Work Phone #: _____ Cell Phone #: _____

Child's Medical History

Name of Child's Physician/Pediatrician: _____ Date of last Medical Exam: _____
Physician's Address: _____ Phone #: _____
Is your child taking any medications? ____ Yes ____No / If yes, please explain: _____
Does your child have any food allergies? ____ Yes _____ No / If yes, please explain: _____
Does your child have any allergies to medications including antibiotics? ____ Yes _____ No
If yes, please explain: _____
Has your child ever been hospitalized? ____ Yes ____ No
If yes, which hospital(s)? _____ When: _____
Reason for hospitalization: _____

Do any of the following apply to your child? Please mark the appropriate column.

	Yes	No		Yes	No
Anemia	___	___	Abnormal Bleeding	___	___
Asthma	___	___	Hepatitis	___	___
Diabetes	___	___	Handicap/Disabilities	___	___
Tuberculosis	___	___	Skin Disorders	___	___
Rheumatic Fever	___	___	Heart Conditions/Murmur	___	___
Premedication needed	___	___	Nose/throat disorders	___	___
Lung disorders	___	___	Hemophilia	___	___
HIV/AIDS	___	___	Cancer/Tumors	___	___
Stomach/kidney problems	___	___	Liver problems	___	___
Convulsions/epilepsy	___	___	Ear problems	___	___
Bone problems	___	___	Speech/vision problems	___	___
Hyperactivity/ADD/ADHD	___	___	Mental/emotional disorders	___	___
Latex allergy	___	___	Premature at birth	___	___
Complications during pregnancy	___	___	Blood transfusions	___	___
Sickle Cell Disease	___	___	Eating disorders	___	___
Thyroid/Gland disorders	___	___	Headaches	___	___
Pregnancy	___	___	Genito-urinary problems	___	___

Please explain any medical conditions/issues about which you would like us to know:

_____

_____

Child's Dental History

Is this your child's first visit for dental care? ____ Yes ____ No

If no, please indicate the following about the previous dentist:

Name: _____Address/City/St: _____

Phone #: _____ Date of last appointment: _____

What is your reason for seeking dental care at this time?_____

_____

Has your child ever suffered any injury to the mouth and/or teeth? ____ Yes ____ No

If so, please explain: _____

Has your child had an unfavorable dental experience? ____ Yes ____ No

If yes, please explain: _____

Diet & Nutrition:

Does your child sleep with a bottle? ____ Yes ____ No / If yes, what is in the bottle? _____

Is your child on a special diet? ____ Yes ____ No

If yes, please explain: _____

Fluoride:

Do you have Fluoride in your water? ____Yes _____No

Do you have well water? ____ Yes ____ No

If yes, has the well water been tested for fluoride? ____ Yes ____ No

Does your child take fluoride supplements? ____ Yes ____ No

Does your child use toothpaste with fluoride? ____ Yes ____ No

Oral Habits:

Does your child use a pacifier: ____ Yes ____ No

Does your child suck a thumb or finger(s)? ____ Yes ____ No

Does your child grind his/her teeth during the day and/or night? ____ Yes ____ No

Oral Hygiene:

How often does your child brush in a day? _____

How often does your child floss in a day? _____

Does your child get assistance with brush and flossing? _____ Yes _____ No

Authorization & Release:

I have answered the questions on this form as accurately as possible and to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform this dental office of any changes to my child's health status. I authorize the dental staff to perform the necessary dental services my child needs. I 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 care to third party payers and/or health practitioners. I authorize the use of radiograph and photographs for the purpose of teaching and scientific publications.

Signature of Parent/Guardian: _____ Date: _____