195 S. Maple Avenue
Ridgewood, New Jersey 07450
(201) 652-7020

PEDIATRIC DENTAL ASSOCIATES

Sari C. Zimmer, D.M.D.#3949
Cynthia G. Pattison, D.M.D.#3918

21-00 Morlot Avenue
Fair Lawn, New Jersey 07410
(201) 794-1906

Today's Date_____

Your Child

_____

Child's First Name Middle Initial Last Name

Nickname_____ Sex_____

Birthdate_____ Age_____

School Grade_____

Child's Home Address_____

City, State, Zip_____

Phone:_____

Hobbies:_____

Pediatrician:_____

Pediatrician Phone #:_____

Address:_____

Date of last physical exam:_____

Responsible Party

_____

First Name Middle Initial Last Name

Relationship_____

Address_____

City, State, Zip_____

Soc. Sec. #_____

Cell Phone #_____

The party who brings the child for their appointment is ultimately responsible for final payment.

Who may we thank for referring you to our practice:

Name:_____

Address:_____

Parent's Marital Status

Single Married Separated Divorced Widowed

☐ **Parent #1**
☐ Guardian

Name_____
Home Phone_____
Work Phone_____
Cell Phone_____
Employer_____
Employer Address_____
Occupation_____
Soc. Sec.#_____
E-mail:_____

☐ **Parent #2**
☐ Guardian

Name_____
Home Phone_____
Work Phone_____
Cell Phone_____
Employer_____
Employer Address_____
Occupation_____
Soc. Sec.#_____
E-mail:_____

Primary Dental Insurance

Insured's Name_____
Birthdate_____
Employer_____ Date Employed_____
Insurance Company_____
Group #_____ ID#_____

Additional Insurance

Insured's Name_____
Birthdate_____
Employer_____ Date Employed_____
Insurance Company_____
Group#_____ ID#_____

Dental History

1. Reason for this visit (Check-up, Toothache, unpleasant dental experience, etc.)_____
2. Is your child taking a fluoride-vitamin? Type & dose_____ Yes_____ No_____
3. Did you ever put your child to bed with a nursing bottle?_____ Yes_____ No_____
4. At what age was your child weaned from the breast / bottle?_____

Medical History

1. Is your child in good health now?_____ Yes_____ No_____
2. Has your child ever been hospitalized?_____ Yes_____ No_____
3. Have there ever been any serious illnesses in the past?_____ Yes_____ No_____
4. Has your child ever had any of the following conditions? (circle if applies)

Behavioral/ Learning Problems	Mental Retardation	HIV+AIDS	Unusual Bleeding	Vision Problem	Congenital birth defects
Autism	Heart condition	Convulsions	Emotional Problems	Blood transfusions/Date	Fainting
ADD/ADHD	Heart murmur	Asthma	Speech Problem	Rheumatic fever	Cancer/Tumors
Hyperactivity	GI/Liver condition	Hepatitis	Chronic ear infections	Bacterial/viral infections	Sleep Apnea/Snoring
PDD	Kidney condition	High fever	Recurrent headaches	Diabetes/Endocrine Problem	Other

5. Is your child taking any medication at this time?_____ Yes_____ No_____
6. Does your child have any allergies / drug reactions (penicillin, codeine, local anesthetic, foods, pollen)? Yes_____ No_____
7. Is your child socially developing at an age appropriate rate?_____ Yes_____ No_____

Comments:_____

Consent for treatment of a minor
I verify the above and give my consent for general dental treatment

_____ _____
Parent / Guardian signature Date

Consent for emergency treatment
During my absence I authorize Pediatric Dental Associates to render any emergency dental treatment deemed necessary.

_____ _____
Parent / Guardian Date

THANK YOU FOR CHOOSING PEDIATRIC DENTAL ASSOCIATES TO CARE FOR YOUR CHILD.
PLEASE DO NOT WRITE BELOW THE DARK LINE

Dr. Preference

0 Any 12 PPR
11 ZPR 17 VPR

Refferal _____
Name_____
Street_____
City_____ St._____ Zip_____
D P F S
FB W

CC: IE_____Ortho_____ Prev Tx:_____
CK_____Ret. 1_____ Oper_____ O.S._____
TA_____Trauma_____ XR_____Ortho_____
MP_____1_____Perm_____ FL_____ Behav_____
CAV_____OR/Sedation_____ LA_____ TMD_____

Past Dental History

Erupt. Age_____LDDS_____
Eating Habits_____Sibs:_____Older: _____Younger
Brush / Floss_____Assisted_____
Previous Trauma_____
_____

		Father	Mother
Oral Habits_____	Decay	_____	_____
_____	Cong Abs / Super	_____	_____
	Ortho	_____	_____

Full Term_____