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

PEDIATRIC DENTAL ASSOCIATES

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21-00 Morlot Avenue
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(201) 794-1906

Today's Date_____

Your Child

_____
Child's First Name Middle Initial Last Name

Nickname _____ Gender _____

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 _____

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

Do you have other children? Yes_____ No_____

Names:_____

Do they currently come to our practice? Yes_____ No_____

Who may we thank for referring you to our practice:

Name: _____

Town: _____

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 you child taking a fluoride-vitamin? Type & dose _____ Yes_____ No_____
3. Did you ever put your child to bed with the breast / bottle?_____ Yes_____ No_____
4. At what age was your child weaned from the breast / bottle? _____
5. Has your child been to a previous dentist? Yes_____ No_____ Who? _____