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

PEDIATRIC DENTAL ASSOCIATES

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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_____ 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?_____

Medical / Social 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. Was your child a full term (9 month) pregnancy? _____ Yes_____ No_____
5. Is your child up to date with their vaccinations? _____ Yes_____ No_____
6. 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

7. Is your child taking any medication at this time?_____ Yes_____ No_____
8. Does your child have any allergies / drug reactions (penicillin, codeine, local anesthetic, foods, pollen)? Yes_____ No_____
9. Is your child socially developing at an age appropriate rate?_____ Yes_____ No_____
10. Are there any special circumstances you would like us to be aware of? _____ Yes_____ No_____

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

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

_____ _____ _____ _____
Parent / Guardian Signature | Date | Parent / Guardian | Date

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

CC: IE_____ Ortho _____ Prev Tx: Oper_____ O.S. _____
Ret. 1_____ XR _____ Ortho _____
TA _____ Trauma_____ FL_____ Behav_____
CAV_____ OR/Sedation_____ LA_____ TMD _____

Past Dental History

Erupt. Age_____ LDDS _____
Sibs:_____
Eating Habits _____
Brush / Floss _____ Assisted _____
Previous Trauma _____
_____

	Birth Father	Birth Mother
Oral Habits _____ Decay	_____	_____
_____ Cong Abs / Super	_____	_____
Ortho	_____	_____