PEDIATRIC DENTAL ASSOCIATES

Cynthia G. Pattison, D.M.D. #3918 Sari C. Zimmer, D.M.D. #3949
195 S. Maple Avenue • Ridgewood, New Jersey 07450 • (201) 652-7020

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. Was your child a full term (9 month) pregnancy? _____ Yes____ No____
3. Is your child up to date with their vaccinations? _____ Yes____ No____
4. Is your child socially developing at an age appropriate rate _____ Yes____ No____
5. Has your child ever been hospitalized? _____ Yes____ No____
6. Have there ever been any serious illnesses in the past? _____ Yes____ No____
7. Is your child taking any medication at this time? _____ Yes____ No____
8. Does your child have any allergies / drug reactions (antibiotics, foods, pollen)? Yes____ No____
9. Are there any special circumstances you would like us to be aware of? _____ Yes____ No____
10. Has your child ever had any of the following conditions? (circle if applies)

Behavioral/ Learning Problems	Developmental Delay	HIV/AIDS	Unusual Bleeding	Vision Problem	Congenital Birth Defects
Autism Spectrum Disorder	Heart Condition	Seizures	Emotional Problems	Blood Transfusions/Date	Fainting
ADD/ADHD	Heart Murmur	Asthma	Speech Problem	Psychiatric Diagnosis	Cancer/Tumors
Headaches	GI/Liver Disease	Kidney Disease	Chronic ear infections	Diabetes/Endocrine Problem	

11. Does your child have any of these oral conditions? (circle if applies)

Lip/Tongue tie	Sleep apnea / snoring	Mouth breather	Excessive drooling
Difficulty with breast feeding	Grinding		

Attestation

I verify that the above information is correct and accurate.

_____ _____

Parent / Guardian Signature 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_____ Frenectomy _____ Grinding _____
Eating Habits _____ Apnea _____ Mouth breather _____
Brush / Floss _____ Assisted _____
Previous Trauma _____
_____

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