

PEDIATRIC DENTAL ASSOCIATES

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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

Parent #2
 Guardian

Name _____
Home Phone _____
Work Phone _____
Cell Phone _____
Employer _____
Employer Address _____
Occupation _____
Soc. Sec. # _____
E-mail: _____

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

- Reason for this visit (Check-up, Toothache, unpleasant dental experience, etc.) _____
- Is your child taking a fluoride-vitamin? Type & dose _____ Yes ___ No ___
- Did you ever put your child to bed with the breast / bottle? _____ Yes ___ No ___
- At what age was your child weaned from the breast / bottle? _____
- 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 _____		
Oral Habits _____	Decay _____	Birth Father _____
	Cong Abs / Super _____	Birth Mother _____
	Ortho _____	

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General Consent for Treatment

Patient: _____ Date of Birth: _____

I give consent for my child to receive dental treatment deemed necessary by the providers at Pediatric Dental Associates. These procedures include, but are not limited to: examinations, oral prophylaxis (cleanings), X-rays, fluoride treatment, sealants, restorations (amalgam or composite fillings and crowns), periodontal (gum) treatment, endodontic (root canal) treatments, extractions, and the use of local anesthetics. I understand that the use of local anesthetics carries a small risk for swelling, bruising, allergic reaction, changes in pain perception, or prolonged anesthesia. This consent shall be considered in effect until rescinded or revoked.

I have answered all of the questions about my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all medical conditions, including allergies. I also understand if my dependent ever have any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment.

(Print your name)

(Relationship)

(Date)

THIS SECTION NEEDS TO BE COMPLETED FOR CHILDREN UNDER 18 YO BY A PARENT OR LEGAL GUARDIAN ONLY.

I affirm that I am the parent or legal guardian for the above named minor child. If I am unable to accompany my child, I give permission for the individual named below to escort my child for dental treatment:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

This consent shall be considered in effect until rescinded or revoked.