Chatham
Dental Associates
P.A.
973-635-5522

Pediatric Dental and Medical History

(17 and under)

Welcome to our office. We appreciate the confidence you place with us to provide your dental care. To assist us in serving you, please complete the following forms. The information provided on this form is important to your dental health. If you have any questions please do not hesitate to ask. Please fill out the forms and print. Please fax to 973-635-6910, mail or bring your completed forms with you. Please do not email the forms back.

Name_____ Nick name_____

Birthdate _____ Childs SS #_____

Parent's Names_____

Address_____

Email Address_____

Cell #_____ Home # _____ Work # _____

Please indicate preferred method of contact:
Email___ Text___ Cell ___ Home___ Work___ **(Number in order of preference)**

Responsible party name _____

Relationship_____

Billing Address *(if different from above)* _____

_____

Responsible Phone # _____

Responsible SS # _____

Whom may we thank for this referral?_____

INSURANCE INFORMATION

Name of insured _____ Relationship_____

Birthdate_____ SS #_____

Name of employer_____

Work #_____Date of employment _____

Address of employer_____

Insurance company_____

Group #_____ ID #_____

Ins. Co. Address_____

DENTAL HISTORY

Y ❑ N ❑ Is this your child's first visit?
If no, when was their last dental visit? _____
Name and address of previous dentist
_____
What is your primary concern regarding your child's dental health? _____

Y ❑ N ❑ Are you satisfied with your past dentistry? If no, what were you not satisfied with. _____

Y ❑ N ❑ Is your child under the care of an orthodontist?
If Yes who? _____

Y ❑ N ❑ Has your child had sealant placed?

Y ❑ N ❑ Does your child's gums bleed when brushing or flossing?

Y ❑ N ❑ Does your child take a fluoride vitamin?

Y ❑ N ❑ Has your child had fluoride treatments every 6 months?

Y ❑ N ❑ Does your child brush at least 2 times a day?

Y ❑ N ❑ Does your child floss?

Y ❑ N ❑ Does your child have bad breath?

Y ❑ N ❑ Does your child use a prescription fluoride toothpaste?

Y ❑ N ❑ Does your child have any oral habits ie. thumb sucking?

Y ❑ N ❑ Does your child frequently drink juice, sports drinks or soda?

In the past did dental treatment make your child nervous?
No☐ Slightly ☐ Moderately☐

Y ❑ N ❑ Does your child wear a protective mouthguard for sports?

Y ❑ N ❑ Does your child use products with Xylitol?

Y ❑ N ❑ Is there any history of an accident resulting in damage to your child's teeth?

HEALTH

Y ❑ N ❑ Is your child's immunizations up to date against childhood diseases?

Y ❑ N ❑ Is your child allergic to latex or anything else such as metals, acrylic or dye? If yes what_____

Y ❑ N ❑ Is your child allergic to any medications?
If yes list_____

Y ❑ N ❑ Does your child have any seasonal allergies? _____
_____

Y ❑ N ❑ Asthma

Y ❑ N ❑ Congenital heart defect/disease?

Y ❑ N ❑ Heart murmur

Y ❑ N ❑ Rheumatic Fever

Y ❑ N ❑ Cystic Fibrosis

Y ❑ N ❑ Sinusitis, chronic adenoid/tonsil infection?

Y ❑ N ❑ Sleep apnea/snoring

Y ❑ N ❑ Gastrointestinal/acid reflux

Y ❑ N ❑ Concerns about weight or eating disorder?

Y ❑ N ❑ Bladder, kidney problems?

Y ❑ N ❑ Arthritis, scoliosis, muscle, bone or joint problems?

Y ❑ N ❑ Rash, eczema, skin problems?

Y ❑ N ❑ Is or has your child been under the care of a speech therapist?

Y ❑ N ❑ Impaired vision, hearing or speech?

Y ❑ N ❑ Developmental disorders, intellectual disability?

Y ❑ N ❑ Cerebral palsy, brain injury, epilepsy or seizures?

Y ❑ N ❑ Autism/autism spectrum disorder?

Y ❑ N ❑ Recurrent or frequent headaches/migraines?

Y ❑ N ❑ Fainting or dizziness?

Y ❑ N ❑ Hydrocephaly or placement of a shunt?

Y ❑ N ❑ Attention deficit/ ADD/ADHD?

Y ❑ N ❑ Behavioral, emotional, communicationor psychiatric problems/treatment?

Y ❑ N ❑ Abuse or neglect history?

Y ❑ N ❑ Diabetes, hyperglycemia or hypoglycemia?

Y ❑ N ❑ Precocious puberty or hormonal problems?

Y ❑ N ❑ Thyroid or pituitary problems?

Y ❑ N ❑ Anemia, sickle cell disease or blood disorder?

Y ❑ N ❑ Cancer, tumor, chemotherapy, radiation therapy, bone marrow or organ transplant?

Y ❑ N ❑ Mononucleosis, tuberculosis, scarlet fever, methicillin resistant staphylococcus aureus MRSA

Y ❑ N ❑ Sexually transmitted disease STD, or human immunodeficiency virus HIV/AIDS?

Y ❑ N ❑ Lactose intolerance, food allergy or diet restrictions?
Please list any medications your child is taking. _____
_____

Y ❑ N ❑ Have you had any serious illness not listed above?
If yes please explain: _____
_____

Y ❑ N ❑ Is there any other significant medical history pertaining to this child or his/her family that the dentist/hygienist should know?
If yes describe_____

List any medications you are taking.

_____

_____

_____

To the best of my knowledge all of the preceding answers are true and correct. I understand that providing incorrect information can be dangerous. I ever have any change in my health or change in my medication I will inform the dentist, hygienist or the dental office.

_____ _____ _____
Signature of patient or legal guardian Date Dentist signature/Date

_____ _____
Relationship to patent Dental hygienist/ Date

Fees and payments:
We make every effort to keep down the cost of your care. You can help by paying upon completion of each visit. Arrangements can be made depending upon special circumstances. An estimate of the charge for any procedure will be given to you upon your request. If you have any dental insurance we will be glad to fill out the proper forms and submit the claim. Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid for by your insurance company.

X_____ X_____

Signature of patient (parent if minor) Date

This signature on file is my authorization for the release of information necessary to process my claim. I hereby authorize payment to the doctor named of the benefits otherwise payable to me.

X_____ X_____

Signature of patient (parent if a minor) Date

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X_____ X_____

Signature of patient (parent if a minor) Date