

Jeffrey R. Moran, D.D.S.

Erina Eccher, D.D.S.



Four Executive Park Drive - Albany, NY 12203-3783
 PH: (518) 489-6972 - Fax: (518) 446-1824
 www.aboutkidsteeth.com

<u>Your Child's Information</u>	<u>General Information</u>
<p style="text-align: right;">Today's Date: _____</p> <p>Child's Name: _____ (Last) (First) (MI)</p> <p>Child's Birthdate: ____/____/____ Child's Age _____</p> <p>Nickname: _____ <input type="checkbox"/> Male <input type="checkbox"/> Female</p> <p>School: _____ Grade: _____</p> <p>Child's Home #: (____) _____ SS #: _____</p> <p>Child's Home Address : _____ (Apt/ Condo #) _____ (City) (State) (ZIP)</p>	<p>Who is accompanying the child today? Name: _____ Relation: _____</p> <p>Do you have legal custody of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No Whom may we thank for referring you? _____</p> <p>Other siblings: _____</p> <p>Previous/ Present Dentist : _____ Last Visit Date : _____</p> <p>Dentist's Phone # :_(____) _____</p> <p>Relative or Friend not living with you: Name : _____ Phone # :_(____) _____ Address : _____ (City) (State) (ZIP)</p>

<u>Parent's Information</u>	
<p>Who is responsible for account? _____</p> <p><input type="checkbox"/> Father <input type="checkbox"/> Step Father <input type="checkbox"/> Guardian</p> <p>Name: _____</p> <p>Birthdate : _____</p> <p>Home_(____) _____</p> <p>Address (If different than Child's): _____ _____</p> <p>Social Security #: _____</p> <p>DL #: _____</p> <p>Wk #:_(____) _____ ext: _____</p> <p>Cell / Other #:_(____) _____</p> <p>Email: _____</p> <p>Employer: _____</p> <p>Employer's Address: _____ _____</p>	<p>Parent's Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated</p> <p><input type="checkbox"/> Mother <input type="checkbox"/> Step Mother <input type="checkbox"/> Guardian</p> <p>Name: _____</p> <p>Birthdate : _____</p> <p>Home_(____) _____</p> <p>Address (If different than Child's): _____ _____</p> <p>Social Security #: _____</p> <p>DL #: _____</p> <p>Wk #:_(____) _____ ext: _____</p> <p>Cell / Other #:_(____) _____</p> <p>Email: _____</p> <p>Employer: _____</p> <p>Employer's Address: _____ _____</p>

If you have Dental Insurance Coverage for the Child, please fill out below:

Name of Subscriber _____

Insurance Co. Name: _____

Insurance Address: _____

Insurance Phone #: _(____)_____

Group # (Plan, Local, or Policy #): _____

If you have Dental Insurance Coverage for the Child, please fill out below:

Name of Subscriber _____

Insurance Co. Name: _____

Insurance Address: _____

Insurance Phone #: _(____)_____

Group # (Plan, Local, or Policy #): _____

Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Dental History

Why did you bring the child to the dentist today? _____

Is the child currently in pain? Yes / No

Does the child have a medical condition that requires antibiotic treatment? Yes / No

Has the child ever had a serious / difficult problem associated with previous dental work? Yes / No

Is the child's water fluoridated? Yes / No

Is the child taking fluoridated supplements? Yes / No

Has the child ever had any pain/ tenderness in his/her jaw joint (TMJ/ TMD)? Yes / No

Does the child brush his/her teeth daily? Yes / No

Floss his/her teeth daily? Yes / No

Child's Physician: _____

Phone #: _(____)_____ Date of Last Visit: _____

Is the child currently under the care of a physician? Yes / No

Please describe the child's current physical health: Good Fair Poor

Please list all prescription / over the counter or herbal supplement drugs that the child is currently taking:

Aside from the items below, please list all drugs/ things that the child is allergic to:

Yes / No Latex Yes / No Metals/ Nickel Yes / No Plastic

Medical History

Has the child experienced the following medical problems?

- | | | | | | |
|---|---|------------------------------------|---|---|-----------------------|
| Y | N | Abnormal Bleeding / Hemophilia | Y | N | Heart Murmur |
| Y | N | ADD / ADHD | Y | N | Hepatitis |
| Y | N | AIDS / HIV+ | Y | N | High Blood Pressure |
| Y | N | Anemia | Y | N | Hives |
| Y | N | Any Hospital Stays / Operations? | Y | N | Kidney Problems |
| Y | N | Artificial Bones / Joints / Valves | Y | N | Liver Problems |
| Y | N | Asthma | Y | N | Low Blood Pressure |
| Y | N | Cancer | Y | N | Lupus |
| Y | N | Chicken Pox | Y | N | Measles |
| Y | N | Congenital Heart Defect | Y | N | Mitral Valve Prolapse |
| Y | N | Convulsions | Y | N | Mononucleosis |
| Y | N | Diabetes | Y | N | Prosthetics |
| Y | N | Epilepsy | Y | N | Rheumatic Fever |
| Y | N | Exposed to HIV, but Neg. | Y | N | Scarlet Fever |
| Y | N | Genetic Disorder | Y | N | Skin Rash |
| Y | N | Handicaps / Disabilities | Y | N | Tuberculosis (TB) |
| Y | N | Hearing Impairment | | | |

Are the child's immunizations current? Yes / No
Anything you would like to discuss with the Doctor in private? Yes / No

Please discuss any serious medical problems the child experiences / ed:

Does the child experience any of the following?

- | | | | | | |
|---|---|-----------------------|---|---|------------------------|
| Y | N | Breast Fed | Y | N | Speech Problems |
| Y | N | Clenching / Grinding | Y | N | Thumb / Finger Sucking |
| Y | N | Lip Sucking/ Biting | Y | N | Tongue / Cheek Biting |
| Y | N | Mouth Breather | Y | N | Tongue Thrust |
| Y | N | Nail Biting | Y | N | Pacifier |
| Y | N | Nursing Bottle Habits | | | |

Our office committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent

Date