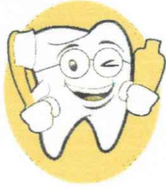

PATIENT INFORMATION

Name of Child:_____________________________________Today's Date: ____________________

Birthdate: _______/_______/______Age:_____Male: (   ) Female: (   ) Nickname: __________________

Hobbies:__________________________________School Name: ______________________________

Patient's Brothers/Sisters and Ages: ____

Home Address:____

Person financially responsible: ____________________________Contact #:_______________________

Is your child adopted? (   ) Yes (   ) No

Does your child have any psychological or emotional problems that you feel should be brought to our attention?

____

Whom may we thank for referring you? ____

DENTAL INSURANCE

Father or Guardian's Name:____________________SS#: __________________Birthdate:__________

Address (if different from patient's) ____

Home #: __________________Work #: _____________________Cell#: ______________________

Employer: ____Position: _________________________

Insurance Co. Name: __________________________________ Phone#: ______________________

Address: ____Group #: ________________________

Mother or Guardian's Name: ______________________SS#: ______________Birthdate: ____________

Address (if different from patient's) ____

Home #: ____________________Work #: _____________________ Cell #: ____________________

Employer: ____Position: _________________________

Insurance Co. Name: _____________________________________Phone#: _____________________

Address: ______________________________________ Group#: _____________________________

DENTAL HISTORY

Date of last visit to a dentist:______________For what service? ________________________________

Name of last dentist? ______________________________Was treatment completed? _______________

Were x-rays taken?______________Date: _______________Was the experience pleasant? if no,

Please explain: ____

Has your child seen an orthodontist? _______Has anyone in your family had orthodontic treatment? _________

If 1st visit to dentist, please check (   ) **Do you desire complete dental care for your child?** YES (   ) No (   )

If no, with what specific problems would you like us to help?

____

Has child complained about dental problems? Yes (   ) No (   )

Does your child brush his/her teeth daily? Yes (   ) No (   )

Does your child floss his/her teeth daily? Yes (   ) No (   )

Is the child's water fluoridated? Yes (   ) No (   ) Is the child taking fluoridated supplements: Yes ( ) No ( )

Does your child suck his/her thumb, fingers, pacifier, nail biting, blankets or sleeping with bottles? ___________

Has your child experienced any cold sores in or around his/her mouth? Yes (   ) No (   )
Does your child have any speech problems? Yes (   ) No (   )
Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? Yes (   ) No (   )

MEDICAL HISTORY

Physician ______________________________________ Last Visit________________

Address______________________________________ Phone__________________

Has your child been hospitalized? _________ When? ________ Why? ______________________

Please list all medications the child is currently taking: ______________________________

List all medications/things the child is allergic to: _________________________________

Latex: Yes (   ) No (   )   Metals/Nickel: Yes (   ) No (   )

Has the child ever had any history of or difficulty with any of the following?

(   ) Abnormal Bleeding   (   ) ADD/ADHD   (   )   (   ) Anemia   (   ) Artificial Bones/Joints/Valves
(   ) Asthma   (   ) Autism   (   ) Cancer   (   ) Cerebral Palsy   (   ) Chicken Pox
(   ) Congenital Heart Defect   (   ) Convulsions   (   ) Diabetes   (   ) Epilepsy   (   ) Fainting
(   ) Handicaps/Disabilities   (   ) Hearing Problems   (   ) Heart Murmur   (   ) Hemophilia
(   ) Hepatitis   (   ) HIV/AIDS   (   ) Kidney/Liver Disease   (   ) Measles   (   ) Mononucleosis
(   ) Rheumatic/Scarlet Fever   (   ) Sensory Issues   (   ) Sickle Cell Disease/Traits   (   ) Tuberculosis

Are the child's immunizations current?   Yes (   ) No (   )

Anything you would like to discuss with the Doctor in private: Yes (   ) No (   )

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name________________________ Relationship________________________ Phone#____________________

To the best of my knowledge, the above information is complete and correct; I understand that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform necessary dental services my child may need.

Signature of parent or guardian ______________________________ Date ____________________

I certify that my child is covered by the above dental insurance company and assign directly to Princeton Pediatric Dentistry all insurance benefits if any, otherwise payable to me. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. I hereby authorize payment directly to Dr. Andy Chung.

Signature of parent or guardian ______________________________ Date ____________________