

Park Avenue Pediatric Dentistry
Dentistry for Infants, Children and Adolescents

Date _____

PATIENT INFORMATION

Patient's name: _____ **Age** _____ **Date of Birth** _____

Address: _____ **Phone #** _____
City, State Zip Code _____

Mother's Name _____ **Occupation:** _____ **Work #** _____ **SS#** _____

Father's Name: _____ **Occupation:** _____ **Work #** _____ **SS#** _____

Cell _____ **Email** _____

How would you like to be contacted _____ **Via e-Mail** _____ **by phone** _____

Sibling(s) _____ **Age(s):** _____

Sibling(s) _____ **Age(s)** _____

Who may we thank for referring you? _____

Emergency Contact(s): _____

Who is responsible for payment of dental treatment? _____

Patient's Pediatrician: _____

Last Physical Exam: _____ **Nanny/ Sitter's Name:** _____

DENTAL HISTORY:

Is patient having any dental discomfort? _____ Bleeding gums? _____

Has patient ever had previous dental treatment? _____ Date of last visit: _____

Any blow or injuries to teeth or face? _____

Name of orthodontist? _____

Is the patient a mouth breather? YES NO

Does any member of the family have missing teeth? _____ History of decay? _____

How does patient behave at pediatrician? _____

How do you think your child will react toward dental treatment? _____

Does your child have any oral habits ---- Circle: Thumb Finger Pacifier?

Is patient being breast fed? _____ Using a bottle _____ Contents: _____

If not, at what age was bottle/breast discontinued? _____

MEDICAL HISTORY:

Has your child had any of the following? Please check all that apply.

	Yes	No		Yes	No
Visual Disorders	—	—	Rheumatoid Arthritis	—	—
Hearing Disorders	—	—	Blood Disorders	—	—
Ear Infections	—	—	Anemia	—	—
Sinus Problems	—	—	Prolonged Bleeding Disorders	—	—
Asthma	—	—	Diabetes	—	—
Tuberculosis	—	—	Thyroid Problems	—	—
Respiratory Problems	—	—	Neurological Disorders	—	—
Rheumatic Heart Disease	—	—	Convulsions/ Seizures	—	—
Heart Murmur	—	—	Fainting	—	—
Cardiac Problems	—	—	Tumors	—	—
Liver Disease/ Hepatitis	—	—	Hyperactivity	—	—
Renal/ Kidney Disease	—	—	Learning Disability	—	—
Intestinal Problems	—	—	ADD/ ADDHD	—	—
Muscular Disorder	—	—	Delayed Speech	—	—
Coordination Problems	—	—	Major/ Minor Surgery	—	—
Oral Herpes	—	—	Hospitalizations	—	—
Special needs	—	—			

Medications: _____

Medication allergies: _____ **allergies:** _____

Latex Sensitivity: _____

Has patient had any disease/ illness not mentioned? _____

Is there anything at all you think we should know about your child?

Was the term of your pregnancy and birth normal? _____

I hereby consent to dental procedures and techniques which the dentist, Dr. Pilla, Dr. Lambert, Dr. Haim and Dr. Spear in attendance deem necessary for the treatment of the patient. I authorize the dentist to provide any information to the other doctors for purpose of consultation. I understand that prior to any treatment I will be advised about it by the dentist or hygienist, which I may ask questions concerning it; and that I may revoke this consent before treatment is provided. I understand that I may ask for a full recital of any or all risks attendant to the care of the patient.

Date: _____

Signed: _____

Parent or Guardian

Date: _____

Signed: _____

D.D.S.

Policies & Procedures

- **Wait time-** Although we pride ourselves on punctuality; please be patient with us if we are running late. We are working with small children that often require extra attention. Our administrative staff will do their best at keeping you updated on your appointment time.
- **Lateness-** If you think you are going to be late for an appointment please call our office. If you arrive 30 minutes late, at the discretion of the doctor we may not be able to see you due to our schedule.
- **Broken Appointment-** If you have 2 broken appointments, you will be automatically charged \$100.00 for your missed appointments. A broken appointment is considered a “no show” or canceling an appointment the same day.

X _____
Parents Signature: