Park View Pediatric Dentistry
Dentistry for Infants, Children and Adolescents

For office use only:	
☐ NP	☐ Update
☐ S	☐ Entered
☐ CC	☐ Rpt
New ped? ☐Y	☐N
Sed: ☐Y	☐N

Date _____

PATIENT AND FAMILY INFORMATION

Patient's Name _____ Age _____ Date of Birth_____

Address _____
Street Apt. City State Zip

Home Phone # _____

Mother's Name _____ Occupation _____

Work # _____ Cell # _____

Email _____

Father's Name _____ Occupation _____

Work # _____ Cell # _____

Email _____

What is the best method above for us to confirm appointments with you? _____

What is the best method above for us to contact you in an emergency? _____

Sibling(s) _____ Age(s)_____

Whom may we thank for referring you? _____

Please note:
For all patients under the age of 18 years, we must speak with a parent/guardian directly before proceeding with their appointment, even if they are accompanied by another family member or trusted caretaker. Thank you for your cooperation.

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Patient's Name _____

DENTAL HISTORY

Is patient having any dental discomfort? _____ Date of last dental visit _____

Has the patient had any injuries to their teeth or face?_____

Is the patient a mouth breather? YES NO

Do any family members have missing teeth? _____ History of decay? _____

Does your child have any oral habits? Circle all that apply: Thumb Finger Pacifier

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

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

MEDICAL HISTORY

Patient's Pediatrician_____ Date of Last Physical Exam _____

How does patient behave at pediatrician?_____

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

Please check all in the following list that apply to your child, checking 'no' where applicable so our records are complete.

	Yes	No
Visual Disorders		
Hearing Disorders		
Ear Infections		
Sinus Problems		
Asthma		
Tuberculosis		
Respiratory Problems		
Heart Murmur		
Cardiac Problems		
Liver Disease/ Hepatitis		
Renal/Kidney Disease		
Intestinal Problems		
Muscular Disorder / Low Tone		
Coordination Problems		
Prolonged Bleeding Disorders		
Major/Minor Surgery		
Hospitalizations		
Diabetes		
Thyroid Problems		
Rheumatoid Arthritis		

	Yes	No
Blood Disorders		
Anemia		
Convulsions/ Seizures		
Fainting		
Tumors		
Hyperactivity		
Learning Disability		
ADD/ADHD		
Delayed Speech		
Speech Therapy		
Sensory Issues		
Oral Sensory Issues		
PDD		
Autism		
Asperger's Syndrome		
Genetic Disorder		
Special Needs		
Occupational Therapy		
Physical therapy		

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Medications: _____

Medication allergies: _____ Other 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 and Dr. Chin, in attendance deems 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, that 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.

Park View Pediatric Dentistry
800A Fifth Avenue Suite 303
New York, NY 10065

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand Park View Pediatric Dentistry has the right to change its Notice of Privacy Practices from time to time. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions. I have received the Health Insurance Portability and Accountability Act (HIPAA) information that was provided by Park View Pediatric Dentistry.

Patient Name (please print): _____

Patient Signature:_____ Date: _____