**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: _____