Natasha A. Larson, DMD

Chelsea
Pediatric Dentistry

Loren C. Buonocore, DMD

Your Child's Name: _____

Nickname _____ Male____ Female____

Date of Birth: _____/_____/_____ Age _____

School:_____ Grade:_____

Child's **primary** address:_____

City/State_____Zip_____Tel:_____

Parent/Legal Guardian #1:

Name: _____

SS#:_____Birthdate: _____/_____/_____

Occupation/Employer: _____

Work phone: _____Ext:_____

Phone: (home)_____(mobile)_____

Email: _____

Parent/Legal Guardian #2:

Name: _____

SS#:_____Birthdate: _____/_____/_____

Occupation/Employer: _____

Work phone: _____Ext:_____

Phone: (home)_____(mobile)_____

Email: _____

Parents' Marital Status (circle one):

Single Married Divorced Widowed Separated

Preferred contact for scheduling appointments: _____

Best day(s)/time to contact you: _____

Best day(s)/time for appointments: _____

Please list the names/ages of any other children you have at home:

_____

_____

Who is accompanying the child today?

Name_____

Relationship to child_____

Do you have legal custody of this child? ___Yes___No

Person Responsible for Account:

Name: _____

Relationship to Child: _____

SS#:_____ Birthdate: _____/_____/_____

Billing Address (if different from child): _____

_____

Work phone: _____ Ext:_____

Phone: (home)_____(mobile)_____

Email: _____

Dental History:

Is this your child's first visit to the dentist? _____Yes _____ No

If not, name/location of previous dentist:

_____

_____

Date of last exam: _____

Were previous x-rays taken? _____ If yes, when? _____

Has your child ever had a negative experience at the dentist?

_____ Yes _____ No

Does your child use Fluoride toothpaste?_____ Yes _____ No

Does your child drink NYC tap water?_____ Amt/day_____

Other sources and amount? _____

How often does your child brush their teeth? _____

Do they get help or do they do it alone? _____

Does your child floss?_____ How often?_____

Please circle if your child has had any of the following problems?

Cavities/Fillings Toothache Gum infections

Grinding/Clenching Sensitivity Jaw discomfort

Sucking habits: Thumb Pacifier Fingers Lip

Other habits: _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain: _____

_____

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

_____

_____

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Health History:

Name of Pediatrician: _____

Address_____ Phone: _____

Current Medications:_____

_____

_____

Allergies: _____

_____

Past Surgeries:_____

_____

Any Implants/Shunts or metal objects (pins/rods): _____

_____

Hospital Stays:_____

_____

Please list any other medical specialists that your child sees:

_____

_____

Who may we thank for referring you to our office?

_____

Has your child ever had any of the following (please circle):

ADD/ADHD	Abnormal Bleeding	Acid Reflux
Anemia	Allergy to Drugs	Allergy to Latex
Anxiety	Asthma	Autism/Aspergers
Cancer	Cerebral Palsy	Bleeding problems
Depression	Cleft Lip/Palate	Congenital Birth Defects
Diabetes	Developmental Delays	Chronic Infections
Heart Disease	Epilepsy/Seizures	Handicaps/Disabilities
Heart Murmur	HIV+/AIDS	Hearing/Speech
Rheumatic Fever	Hearing/Speech Impairments	Liver Disease
PDD	ODD	Kidney Disease
Pregnancy	Physical Therapy	Thyroid Disease

Other:_____

_____

Please explain any medical problems your child has: _____

_____

_____

HIPAA Privacy Practices Notification

I, the undersigned parent/legal guardian of_____ (print child's name), have been issued the HIPAA Notice of Privacy Practices. I fully understand that the Practice is required by law to maintain the privacy of my child's medical and health information. I acknowledge that the Practice will use and disclose my child's health information for the purposes of treating my child, obtaining payment for services rendered to my child and conducting health care operations.

Signature of parent/legal guardian _____ Date _____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can put my child's health at risk. Furthermore, I understand that it is my responsibility to inform this dental office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services that my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such dental care to third party payors and/or other health practitioners as necessary. I hereby authorize the Doctors of Chelsea Pediatric Dentistry, PC to perform the examination and after explanation, any and all treatment for the above named child including radiographs if indicated and consent to such methods, drugs and agents that may be indicated in connection with his/her dental care. This consent shall remain in effect until cancelled. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I understand that, as a condition of my child's treatment by this office, financial arrangements must be made in advance.

Signature of parent/legal guardian _____ Date _____