RIVERDALE PEDIATRIC DENTISTRY

Today's Date: _____

PATIENT INFORMATION

Child's Name: _____ Nickname: _____
FIRST LAST

Birth Date: _____ Age:_____ ☐Boy ☐Girl Home Phone #: _____

Home Address: _____
STREET APT. # CITY STATE ZIP

Sibling Name(s), Age(s): _____

Referred By: _____ Child's School: _____ Grade: _____

Child's Favorite Hobbies/Characters: _____

FAMILY INFORMATION

Mother's Name: _____ (☐LEGAL GUARDIAN) Email: _____

Home Address: _____
(☐**SAME AS CHILD'S**) STREET APT. # CITY STATE ZIP

Cell #: _____ Home Phone #: _____ Work Phone #: _____
(AREA CODE) (☐ SAME AS CHILD'S) (AREA CODE)

Occupation: _____SS#: _____ Is this person responsible for payment? ☐Yes ☐No

Father's Name: _____ (☐LEGAL GUARDIAN) Email: _____

Home Address: _____
(☐**SAME AS CHILD'S**) STREET APT. # CITY STATE ZIP

Cell #: _____ Home Phone #: _____ Work Phone #: _____
(AREA CODE) (☐SAME AS CHILD'S) (AREA CODE)

Occupation: _____SS#: _____ Is this person responsible for payment? ☐Yes ☐No

INSURANCE INFORMATION

Co. Name: _____ Phone #: _____
(AREA CODE)

Co. Address: _____
STREET APT. # CITY STATE ZIP

Insured's Name: _____ Insured's Birth Date: _____ Insured's ID #: _____

Group # (Plan/Local/Policy #): _____ Relation to Patient: _____ Employer: _____

CHILD'S DENTAL INFORMATION

Reason for visit: ☐1st Dental Visit ☐6 Month Checkup ☐Consultation ☐Emergency Is child in pain? ☐Yes☐No
Please indicate if child has any of the following problems:

☐Blows/injuries to the face
☐ Discomfort/clicking/popping in jaw
☐Teeth Grinding
☐ Blisters/sores in or around mouth
☐Sore spots/growths
☐ Lost/broken fillings
☐Locking jaw
☐ Broken/chipped tooth
☐ Stained teeth
☐ Sensitive teeth/gums
☐Loose tooth
☐ Red/swollen/bleeding gums
☐ Ringing in ears
☐ Bad breath
☐ Other_____

Does the child have these habits? ☐Y ☐N Thumb/finger sucking ☐ Y ☐N Heavy snoring ☐ Y ☐N Teeth grinding
☐Y ☐N Tongue thrusting/sucking ☐ Y ☐N Lip sucking/biting ☐ Y ☐N Pacifier

Patient Name:_____

Previous Dentist: _____Date of last dental exam: _____

(A DENTIST CHILD HASN'T SEEN IF YET)

Is the child undergoing orthodontic treatment? ☐No ☐Yes If yes, list orthodontist's name, #: _____

CHILD'S MEDICAL HISTORY

Child's Physician: _____ Phone #: _____ Date of last exam: _____

(AREA CODE)

Dr's. Address: _____

STREET APT. # CITY STATE ZIP

Please indicate if your child has had any of the following:

☐ Y ☐N ADD/ADHD
☐ Y ☐N Anemia
☐ Y ☐N Artificial Heart Valves/ASD/VSD
☐ Y ☐N Artificial Joints/Bones/ Implants
☐ Y ☐N Asthma
If yes, list date of last attack: _____
Hospitalized for attack?: _____
Med(s):_____
Trigger(s):_____
☐ Y ☐N Autism
☐ Y ☐N Birth Defects
☐ Y ☐N Bleeding Disorders
☐ Y ☐N Blood Disorders/Hemophilia
☐ Y ☐N Blood Transfusions
☐ Y ☐N Cancer/Tumors
☐ Y ☐N Cerebral Palsy/Seizures/ Epilepsy
☐ Y ☐N Chemotherapy
☐ Y ☐N Cleft Lip Lip/Palate
☐ Y ☐N Congenital Heart Defect/Disease
☐ Y ☐N Coordination Problems
☐ Y ☐N Delayed Speech
☐ Y ☐N Diabetes
☐ Y ☐N Fainting/Convulsions
☐ Y ☐N Hearing Disorders
☐ Y ☐N Heart Murmur
☐ Y ☐N High/Low Blood Pressure
☐ Y ☐N HIV+/AIDS/ARC
☐ Y ☐N Hospitalizations
☐ Y ☐N Hyperactivity
☐ Y ☐N Intestinal Problems
☐ Y ☐N Jaw Problems/TMJ/TMD
☐ Y ☐N Learning Disability
☐ Y ☐N Leukemia
☐ Y ☐N Liver Disease/Hepatitis
☐ Y ☐N Muscular Disorders
☐ Y ☐N Neurological Disorders
☐ Y ☐N Oral Herpes
☐ Y ☐N PDD Spectrum
☐ Y ☐N Psychiatric Problems
☐ Y ☐N Renal/Kidney Disease
☐ Y ☐N Respiratory Problems
☐ Y ☐N Rheumatic Fever
☐ Y ☐N Rheumatoid Arthritis
☐ Y ☐N Scarlet Fever
☐ Y ☐N Sensory Issues
☐ Y ☐N Sinus Problems
☐ Y ☐N Surgeries/Operations
If yes, list date(s): _____
Reason(s): _____
☐ Y ☐N Thyroid Problems
☐ Y ☐N Tonsillitis
☐ Y ☐N Tuberculosis
☐ Y ☐N Visual Disorders

Has your child been vaccinated? ☐Yes ☐No

Does child require pre-medication? ☐Yes ☐No

Does the child have any condition that requires medication? ☐Yes ☐No If yes, list me_____

Any allergies? ☐ Y ☐N Penicillin ☐ Y ☐N Latex ☐ Y ☐N Seasonal ☐ Y ☐N Food ☐ Y ☐N Other: _____

List any other medical condition(s) the child has or had: _____

Has child been hospitalized over night? _____ If yes, for what reason(s) and how long: _____

■ We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.
■ Our policy requires payment in full for all services rendered at the time of visit. If account is not paid within 30 days of the date of service, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collection your account.
■ I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
■ I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Print Name: _____ Signature: _____ Date: _____

Doctor Name: Liraz Spear, DDS, FAAPD **Signature: _____ Date: _____**