BRONX KIDS
Pediatric Dentistry

1) Patient Information:

Child's Name _____ Nickname _____
Last, First MI

Birthdate ____/____/_____ Child's Age _____ (Circle gender of child) Male Female

Child's Home Address_____

City _____ State _____ Zip_____

Child's Home Phone # (_____) _____

Person Filling out Form: (Circle) Mother Father Other_____

Are you the Child's Legal Guardian? Yes No

How would you like to receive appointment reminders? (You may circle more than one)
Email Phone Call Text Message Other_____

Mother/Guardian:

Name _____

Birthdate ____/_____/_____

Employer _____

Work Phone #

(____) _____

Cell Phone #

(____) _____

E-mail _____

Father/Guardian:

Name _____

Birthdate ____/_____/_____

Employer _____

Work Phone #

(____) _____

Cell Phone #

(_____) _____

Email_____

How did you find us?

( ) Another Doctor/Dentist?
_____

( ) Insurance Company?
_____

( ) Family/Friend
_____

( ) Other
_____

3) Primary Dental Insurance:

Person Responsible for Account _____
Billing Address_____
City_____ State_____ Zip _____
Date of Birth _____/_____/_____ SSN _____
Relationship to patient _____
Insurance Company Name _____
Telephone # of Insurance Company (_____)_____
Group # _____ Policy holder ID#_____

4) Child's Health History

Name of Pediatrician _____ Number_____
Date of last visit _____/_____/_____
Please provide the name of any specialty doctors if applicable.
Name of Specialist/Specialty _____ Number _____

Please review carefully and circle if your child has any history of, or condition related to, any of the following:

- ADHD/ADD
- Anemia
- Arthritis
- Asthma
- Autism
- Bladder/Kidney
- Bleeding Disorders (prolonged bleeding)
- Bone Disorders
- Cancer, Malignancy, Tumors
- Cerebral Palsy
- Chicken Pox
- Diabetes
- Earaches/Infection
- Enlarged Tonsils/Adenoids
- Epilepsy/Seizures
- Fainting
- Growth Problems
- Headaches
- HIV+/AIDS
- Latex Allergy
- Liver/Hepatitis
- Measles
- Pregnancy
- Rheumatic Fever
- Sickle Cell Disease /Trait
- Snoring
- Speech/Hearing
- Skin
- STD
- Thyroid
- Tobacco/Drug Use
- Vision Disorders
- Other_____

Is your child taking any medications (prescription, OTC, vitamins)? Yes No
Please list all medications
_____
Is your child allergic to any medications? Yes No
Please list_____

Does your child have:

Latex allergies? Yes No **Metal** allergies? Yes No
Food allergies? Yes No Other allergies? _____

Has your child ever been hospitalized overnight? Yes No
Has your child ever had surgery? Yes No

Has your child had any complications from sedation or general anesthesia? Yes No
Does your child have any mental, developmental, or physical impairment? Yes No
Has your child ever experienced excessive bleeding when cut or injured? Yes No
Does your child have any medical conditions not discussed on this form? Yes No

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5) Dental Information

Is this your child's first dental visit? (Yes No) If not, date of last visit?_____
Has your child recently complained of any dental pain? Yes No
If yes please explain: _____
Has your child ever incurred any injuries to the head, mouth, or teeth? Yes No
If yes please explain:
_____
Has your child had an unfavorable experience at a previous dental visit? Yes No

Is your child currently using a bottle? (Yes No) Sippy cup? (Yes No)
Does your child suck his/her fingers? (Yes No) Pacifier? (Yes No)

I understand that the information I have given is correct to the best of my knowledge and that it will be held in the strictest of confidence. I understand that the withholding or misrepresentation of medical or dental information can be harmful to my child during treatment. I consent that it is my responsibility to inform the office of any changes in my child's medical status.

I authorize Dr. Nyer, Dr. Zultowsky and their dental team at Bronx Kids Pediatric Dentistry PLLC to take dental radiographs "x-rays" as may be considered necessary by Dr. Nyer and Dr. Zultowsky to diagnose and / or treat my child's dental problems. I assign Bronx Kids Pediatric Dentistry PLLC all insurance benefits. I understand that I am ultimately responsible for payment of services rendered regardless of insurance benefits. Deductibles and co-payments will be required to be paid prior to commencing dental services.

Parent/Guardian's Signature: _____

Date: _____

Doctor's Signature: _____

Date: _____