Ehrenman & Khan
PEDIATRIC DENTISTRY

959 Brush Hollow Road • Suite 101 • Westbury, NY 11590
Phone 516.333.3033 • www.KidsTeeth4LI.com

## DENTAL HISTORY

❑ Yes ❑ No Has your child ever had a dental visit?
What type of treatment was completed? _____
Name of dentist _____Date_____
Was your child ❑ Bottle Fed ❑ Breast Fed At what age was it stopped _____

❑ Yes ❑ No Has your child experienced any unfavorable reaction from previous dental care?
If yes, explain_____

❑ Yes ❑ No Does your child, or did s/he ever suck a finger, thumb or pacifier? ❑ Current ❑ Stopped age ____

***Please check the appropriate box if your child is having problems with any of the following:***

| | | |
|---|---|---|
| ❑ **Cavities** | ❑ **Toothache** | ❑ **Teeth Sensitive** |
| ❑ **Trauma** | ❑ **Gum Infections/Swellings** | ❑ **Color of Teeth** |
| ❑ **Crowded Teeth** | ❑ **Jaw Sounds** | ❑ **Other**_____ |

***Comments:***_____

❑ Yes ❑ No Does your child use fluoridated toothpaste?

❑ Yes ❑ No Do you give your child any other form of fluoride? If yes, what? _____

## HEALTH HISTORY

Name of child's physician_____ Phone_____
Address _____

❑ Yes ❑ No Is your child in good health? Date of last physical exam _____
❑ Yes ❑ No Has your child ever had a health problem? _____
❑ Yes ❑ No Has your child ever been hospitalized or had surgery?
*Please give dates and reasons* _____
❑ Yes ❑ No Is your child **allergic** to anything? If so, what? _____
❑ Yes ❑ No Is your child currently taking any medications?
*Please give medication and reason* _____
❑ Yes ❑ No Were there any problems at birth? _____

**Preferred Pharmacy** _____ Address _____ Phone#_____

***Please check the appropriate box if your child has been treated for any of the following:***

| | | | |
|---|---|---|---|
| ❑ **ADD/ADHD** | ❑ **Cerebral palsy** | ❑ **Diabetes** | ❑ **Liver/GI disease** |
| ❑ **Allergies to foods** | ❑ **Chronic adenoid/ tonsil infection** | ❑ **Fainting** | ❑ **Physical delays** |
| ❑ **Allergies to medicine** | | ❑ **Heart disease** | ❑ **Premature birth** |
| ❑ **Anemia** | ❑ **Chronic ear infections** | ❑ **Heart murmur or defects** | ❑ **Rheumatic fever** |
| ❑ **Asthma** | ❑ **Cleft lip/palate** | ❑ **Hemophilia** | ❑ **Seizures/Epilepsy** |
| ❑ **Autism** | ❑ **Congenital birth defects** | ❑ **Hepatitis** | ❑ **Speech/hearing** |
| ❑ **Bleeding/transfusions** | ❑ **Developmental delay** | ❑ **Kidney disease** | ❑ **Thyroid disease** |
| | | | ❑ **Other**_____ |

***Please elaborate on any items checked:*** _____

_____

Ehrenman & Khan
PEDIATRIC DENTISTRY

959 Brush Hollow Road • Suite 101 • Westbury, NY 11590
Phone 516.333.3033 • www.KidsTeeth4LI.com

## PATIENT INFORMATION

Today's Date_____

Patient Name_____Birthday_____ Sex: ❑ Male ❑ Female

Names & ages of siblings_____

Your relationship to patient: ❑ Mother ❑ Father ❑ Guardian ❑ Other_____

Whom may we thank for referring you to us? _____

What is the reason for your child's dental visit? _____

How do you expect your child to react to his/her visit today? ❑ Excellent ❑ Good ❑ Fair ❑ Poor ❑ Don't Know

## FINANCIAL AND INSURANCE INFORMATION

Patient's Name_____

Father's Name _____
❑ Single ❑ Married ❑ Divorced
Address _____
_____
Home Phone _____
Cell Phone _____
Email _____

Mother's Name _____
❑ Single ❑ Married ❑ Divorced
Address ❑ Same
_____
Home Phone _____
Cell Phone _____
Email _____

**Do you have dental insurance coverage for your child? ❑ Yes ❑ No**

Employer _____ Work Phone _____
Policy Holder Name_____ Soc. Sec. #_____Birthdate_____
Ins. Co. Name _____ Ins. Phone #_____
Address _____
Group #_____ Member ID # _____

## RELEASE AND ASSIGNMENT

I certify that my minor/child is covered by insurance with (*Name of Insurance Company*) _____ and assign directly to"Ehrenman & Khan Pediatric Dentistry" all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize "Ehrenman & Khan Pediatric Dentistry" to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

## AUTHORIZATION AND FINANCIAL RESPONSIBILITY

Because your child is a minor, it becomes necessary that signed permission be obtained from a parent or guardian before any/all necessary services can be performed. I acknowledge that the above information is correct. I authorize the doctors and staff to take x-rays, photographs or other diagnostic aids deemed appropriate to make a thorough diagnosis and grant this office permission to provide my child's dental treatment. This consent is also valid for emergency treatment, even in my absence. Furthermore, I understand that I am responsible for the cost of all dental care provided in this office.

Signature of Parent or Guardian_____ Relationship to Child_____Date_____