Ehrenman & Khan
PEDIATRIC DENTISTRY

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

DENTAL HISTORY

Patient Name_____Birthdate_____

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

Please elaborate on any items checked: _____

_____

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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

Father's Name _____

❑ Single ❑ Married ❑ Divorced

Address _____

_____

Home Phone _____

Cell Phone _____

Work Phone _____

Email _____

Mother's Name _____

❑ Single ❑ Married ❑ Divorced

Address ❑ Same

_____

Home Phone _____

Cell Phone_____

Work Phone _____

Email _____

PRIMARY DENTAL INSURANCE

Policy Holder _____

SS#_____Birthdate_____

Employer_____

Insurance Company _____

Group #_____ID#_____

SECONDARY DENTAL INSURANCE

Policy Holder _____

SS#_____Birthdate_____

Employer_____

Insurance Company _____

Group #_____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_____