

Children's Dentistry of Morristown



Suzy Harrison Press, DDS, MS • Spec. Lic. #3875
 Lisset Penton, DDS • Spec. Lic. #5171
 Archana Devi, DDS • Spec. Lic. #5330
 95 Madison Ave. • Morristown, NJ 07960
 (973) 898-6600

Childrendentistry@verizon.net

Child's Name _____ Male Female
 Nickname _____ Date of Birth _____ Child's age _____
 Address _____
 city _____ state _____ zip _____ home phone _____
 work phone _____ cell phone _____ E-mail _____
 Names & age of brothers & sisters _____
 Have your brothers/sisters been seen in this office? _____

Who shall we thank for referring you to our office? _____

Child's physician/pediatrician _____
 Address & phone _____
 Date of last medical exam _____ Are all immunizations up to date? _____
 Is your child presently under the care of a physician? _____
 If yes, please explain _____
 Does your child have any unusual physical condition? _____
 If yes, please explain _____
 Is your child taking any medication? _____
 Has your child ever had any unusual reactions to any medications? _____
 What has been your child's experience with immunizations/vaccinations? _____

Has your child had any of the following?

- | | | | | |
|---|---|---|--|---|
| <input type="checkbox"/> ADD/ADHD | <input type="checkbox"/> convulsions | <input type="checkbox"/> immune disorders | <input type="checkbox"/> psychiatric evaluations | <input type="checkbox"/> seizures |
| <input type="checkbox"/> allergies | <input type="checkbox"/> diabetes | <input type="checkbox"/> HIV | <input type="checkbox"/> past hospitalizations | <input type="checkbox"/> venereal disease |
| <input type="checkbox"/> asthma | <input type="checkbox"/> glandular problems | <input type="checkbox"/> Kidney problems | <input type="checkbox"/> rheumatic fever | <input type="checkbox"/> other |
| <input type="checkbox"/> bleeding disorders | * <input type="checkbox"/> heart problems | <input type="checkbox"/> liver disease | <input type="checkbox"/> respiratory disorder | <input type="checkbox"/> cancer |
| <input type="checkbox"/> brain injury | * <input type="checkbox"/> heart murmur | <input type="checkbox"/> pregnancy | <input type="checkbox"/> scarlet fever | |

Note: it is very important for the health of your child that medical clearance for a heart murmur/problems be documented

MOTHER'S INFORMATION

Name _____
 Address _____
 city _____ state _____ zip _____
 Home phone _____
 DOB _____
 SS# _____
 Employer _____
 Address _____
 city _____ state _____ zip _____
 Work phone _____
 Dental insurance _____
 Group # _____ Primary Secondary

FATHER'S INFORMATION

Name _____
 Address _____
 city _____ state _____ zip _____
 Home phone _____
 DOB _____
 SS# _____
 Employer _____
 Address _____
 city _____ state _____ zip _____
 Work phone _____
 Dental insurance _____
 Group # _____ Primary Secondary

DENTAL HISTORY INFORMATION

What is the Chief Reason for this visit? _____

Has your child received dental care before? ____ If yes, please explain _____

Has your child experienced any major injury to the face or teeth? ____ If yes, please explain _____

Does your child have any of the following?

thumb sucking finger sucking pacifier teeth grinding mouth breathing nail biting lip biting

Was your child breast/bottle fed? breast bottle To what age? _____

Does/ did your child fall asleep with a bottle or while nursing? _____

What types and how often does your child snack? _____

How often does your child brush? _____

Has your child ever had a fluoride treatment? _____

Is your child taking a fluoride supplement? _____ If so, which one? _____

CONSENT FOR TREATMENT

I certify that the above information is true and correct. I also, give consent for my child to be examined and receive dental treatment as the dentist deems fit after consultation with the parent.

Patient who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is personally responsible for payment of all dental services.

A service charge of 1 ½% per month (18% per annum) on the unpaid balance will be charges on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

A \$75.00 fee will be incurred for missed appointments without 24 hours notice.

I understand that payment is expected for services at the time it is rendered unless previous arrangements have been made or within five (5) days of billing if credit shall be extended.

I grant permission to your assignee to telephone me at home or work to discuss matters related to this form.

Signature _____ date _____

Relationship to patient _____