



**Manhattan
Pediatric Dental Group**

**192 East 75th Street
New York, New York 10021
Phone: (212) 570-2221**

Patient Information and History

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful ***smile that lasts a lifetime.***

Please fill out this form completely.

Date:

Child's Name:(M/F) Nickname:

Date of Birth: Brother/Sisters(Ages):

Child's Address: Phone:

Your Name: Relation to Child: e-mail:

Your Address (if different):

Husband's / Wife's Name:

Are you: Married Single Separated Widowed Divorced

Who is responsible for this account?

Address of this person:

Employed by: Type of Work:

Business phone of Father: Business phone of Mother:

Cell phone of Father: Cell phone of Mother:

Whom may we thank for referring you?

Where / Whom may we call regarding your appointment?

Child's Physician: Phone:

Parent's Dentist: Phone:

Social Security# :

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Medical and Dental History

Please answer applicable questions by circling and elaborate below if "Yes"

- Does your child have any health problems? Yes No
 Has your child seen a physician in the last year? (other than checkups) Yes No
 Has your child ever been hospitalized? Yes No
 Does your child take medicines regularly? Yes No
 Is your child taking vitamins with Iron? Yes No
 Is your child allergic to penicillin or other substances? Yes No
 Does your child have an emotional or nervous problem? Yes No
 Has your child ever had a history of: (please write "yes" or "no" and elaborate below)

Heart murmur Asthma Bleeding Disorder Heart Trouble Anemia

Kidney/Liver Disorder Rheumatic Rheumatic Fever Diabetes Epilepsy/Convulsions

Speech Problems Tuberculosis Any Unusual Conditions

- Does your child have any dental problems now? Yes No
 Has your child ever been to a dentist before? Yes No
 Was the visit a good experience? Yes No
 Has your child seen a dentist in the last 6 months? Yes No
 Has your child ever had dental x-rays? Yes No
 Has your child's experience with other doctors been pleasant? Yes No
 Has your child ever had a toothache? Yes No
 Have your child's teeth ever been injured in an accident? Yes No
 Does your child have any oral habits? (pacifier, thumb, finger, nail biting) Yes No
 Do you help brush your child's teeth? Yes No
 Does your child have a bottle with milk or juice? Yes No
 Does your child fall asleep with a milk or juice bottle? Yes No
 Do you nurse your child to sleep? Yes No

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has a change in his/her health or medicines, I will inform the doctors. I hereby authorize treatment by the doctors in caring for my child.

Signed:

Dated:

ADDITIONAL COMMENTS: