Welcome to Smile Starters Pediatric Dentistry!

15 Verbena Avenue
Floral Park, New York 11001
TEL: (516) 784-4100 FAX: (516) 784-4161

We are thrilled to welcome you and your family. Please fill out this form as completely as possible. If you have any questions, we are happy to help.

Patient's Information and Health History

Child's Full Name _____ Nickname _____

Date of Birth _____ Age_____ Sex: ☐ *M* ☐ *F* Grade_____

Patient lives with: ☐ Mother ☐ Father ☐ Both ☐ Other

Name(s) and age(s) of other children in family _____

Name(s) of other children seen in this office _____

Whom may we thank or referring you to our office? _____

Is this your child's first visit? *Yes* *No* If no, name of former dentist _____

Who is your family dentist? _____

Parents' Marital Status ☐ *Single* ☐ *Married* ☐ *Separated* ☐ *Divorced* ☐ *Widowed*

Guarantor (Person responsible for payment of dental services)

Guarantor_____

Relationship ☐*Mother* ☐*Father*

☐*Guardian* ☐*Stepmother* ☐*Stepfather*

Date of Birth_____ SS # _____

Address_____

City_____ State_____ Zip _____

Primary (Daytime) Phone _____

Secondary (Cell) Phone _____

Email_____

Driver's License #_____ State _____

Secondary Contact

Name_____

Relationship ☐*Mother* ☐*Father*

☐*Guardian* ☐*Stepmother* ☐*Stepfather*

Date of Birth_____ SS # _____

Address_____

City_____ State_____ Zip _____

Primary (Daytime) Phone _____

Secondary (Cell) Phone _____

Email_____

Driver's License #_____ State _____

Insurance Information - **Please give all your insurance cards to the receptionist.** *If no insurance, check here:* ☐ *Self Pay*

Primary Insurance_____ Relationship to Patient _____

Employer_____ Group #_____ Member ID _____

Secondary Insurance_____ Relationship to Patient _____

Employer_____ Group #_____ Member ID _____

Pharmacy Information

Name_____ Phone _____

Address_____

Medical History

Child's Name:_____

Child's Physician_____ Phone _____

Is your child currently under the care of a physician? ☐ *Yes* ☐ *No*

If yes, please explain: _____

Please describe your child's current physical health. ☐ *Good* ☐ *Fair* ☐ *Poor*

Are all immunizations up-to-date? ☐ *Yes* ☐ *No*

Does your child have any allergies to latex/medications (Penicillin etc) /food/other? ☐ *Yes* ☐ *No*

If yes, please list: _____

Has your child been diagnosed with or treated for any of the following:

- ☐ *AIDS/HIV*
- ☐ *Anemia*
- ☐ *Any Hospital Stays/Surgeries*
- ☐ *Asthma*
- ☐ *ADHD*
- ☐ *Autism*
- ☐ *Cerebral Palsy*
- ☐ *Cleft Palate/Lip*
- ☐ *Diabetes*
- ☐ *Epilepsy/Seizures*
- ☐ *Hearing/Speech Issues*
- ☐ *Heart Disease*
- ☐ *Heart Murmur*
- ☐ *Hemophilia Type* _____
- ☐ *Hepatitis Type* _____
- ☐ *High / Low Blood Pressure*
- ☐ *Kidney Problems*
- ☐ *Learning Disabilities*
- ☐ *Liver Problems*
- ☐ *Sinus Problems/Sleep Apnea*
- ☐ *Tuberculosis (TB)*

If yes to any of the above or other not listed, please explain _____

Please list all medications your child is taking _____

Dental History

What is the **primary** reason for your visit today? _____

Does your child currently have problems with any of the following?

- ☐ *Cavities*
- ☐ *Gum Infection*
- ☐ *Toothache*
- ☐ *Tongue habit*
- ☐ *Oral habits*
- ☐ *Bites fingernails*
- ☐ *Tooth Alignment*
- ☐ *Speech*
- ☐ *Trauma*
- ☐ *Color of Teeth*
- ☐ *Sensitive Teeth*
- ☐ *Other* _____

Has your child experienced problems with previous dental work? ☐ *Y* ☐ *N*

Please explain _____

Previous Dentist_____ Date of last visit _____

Why did you leave your last dentist? _____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize Dr. Georgescu, Dr. Calamia, and associates perform necessary dental procedures including, but not limited to, the use of nitrous oxide, local anesthesia and take any necessary radiographs to diagnose and/or treat my child's dental needs. I also authorize Dr. Georgescu and Dr. Calamia to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payer and/or other healthcare practitioners.

Signature of Patient (or Parent/Guardian if minor)_____ Relationship_____

Please Print Name_____ Date _____