

Welcome to Smile Starters Pediatric Dentistry!

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HARRISON, NY 10528
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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 _____

Age _____ Sex: M F Grade _____ Patient lives with:

Date of Birth 01/19/2021

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 _____

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 _____

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 _____