Schenectady Pediatric Dentistry

Battiste Orthodontics

Today's Date:

① About Your Child

Child's Name:

Nickname: Male Female

Email Address:

Birthdate: Age:

Child's Home Address:

Child's Home Phone:

Hobbies/Sports:

School:

Whom may we thank for referring you to our practice?

General Dentist

Phone #: Date of last visit:

② Who Is Accompanying Your Child Today?

Name: Relation:

Do you have legal custody of this child? Yes No

Please list siblings with ages:

Parent's Marital Status:

Single Partnered Divorced

Married Separated Widowed

③ Mother's Information: Step Mother Guardian

Name: Birthdate:

Email:

Cell #: Service Provider:

For appointment reminders please circle text, email or both?

Employer: Work #:

SS #:

Father's Information:

Name: Birthdate:

Email:

Cell #: Service Provider:

For appointment reminders please circle text, email or both?

Employer: Work #:

SS #:

④ Dental Insurance

PRIMARY

Dental Coverage: YES NO Orthodontic Coverage: YES NO

Policy Holder's Full Name:

Insurance Company Name:

Insurance Company Address:

Insurance Compancy Phone #:

Group #: ID #:

Social Security Number:

Policy Owner's Birthdate: :

Policy Owner's Employer:

Employer's Address:

SECONDARY

Dental Coverage: YES NO Orthodontic Coverage: YES NO

Policy Holder's Full Name:

Insurance Company Name:

Insurance Company Address:

Insurance Company Phone #:

Group #: ID #:

Social Security Number::

Policy Owner's Birthdate:

Policy Owner's Employer:

Employer's Address:

⑤ Person Responsible For Account

Name: Relation to Patient:

Authorization: I certify that I am covered by _____ Insurance company and I assign directly to Dr. Battiste all insurance benefits otherwise payable to me. I hereby authorize the dentist 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.

_____ _____

Signature Date

CONTINUED ON BACK…

⑥ Medical History

Your child's physical health is: Good Fair Poor

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

Please explain:

Is your child taking any medications including over the counter?

Please list:

Has your child ever had any of the following diseases or medical problems?

Y	N	Abnormal Bleeding	Y	N	Developmental Delay
Y	N	ADD/ADHD	Y	N	Ear Infections
Y	N	Allergies	Y	N	Hearing or Vision Impairment
Y	N	Any Hospitalizations	Y	N	Heart Conditions
Y	N	Artificial Joints/Valves	Y	N	Hepatitis
Y	N	Asthma or lung problems	Y	N	HIV+/AIDS
Y	N	Autism	Y	N	Kidney/Liver Problems
Y	N	Behavioral Problems	Y	N	Rheumatic/Scarlet Fever
Y	N	Cancer	Y	N	Speech Problems
Y	N	Cleft Lip and/or Palate	Y	N	Stomach problems/GI/GERD
Y	N	Convulsion/Epilepsy	Y	N	Syndromes/Birth defects
Y	N	Currently Pregnant	Y	N	Thyroid disease
Y	N	Diabetes	Y	N	Tobacco Use
Y	N	Surgeries	Y	N	Tuberculosis

Please describe any medical problems that your child has had:

Are you allergic to any of the following?

Y N Food Y N Medications Y N Latex

Y N Metals/plastics Y N Other

Please list any drugs/materials that your child is allergic to:

⑦ Dental History

What are your main concerns about your child's teeth?

Has your child ever been evaluated for orthodontic treatment? Yes No

Has your child ever had a problem with previous dental work? Yes No

Has your child now or ever experienced pain or discomfort in their jaw joint (TMJ/TMJD)? Yes No

Your child's current dental health is: Good Fair Poor

Are you happy with your child's smile? Yes No

How often does your child brush? (times per day)

How often does your child floss? (times per day)

Has your child ever had an injury to their mouth, teeth or chin? Yes No

Does your child have any speech problems? Yes No

Does your child generally breathe through their mouth? Yes No

If yes, please circle: While Awake While Asleep

When was your child's last dental visit? Were x-rays taken?

Have your child's adenoids or tonsils been removed? Yes No

Has your child ever experienced any of the following?

Y	N	Dry Mouth	Y	N	Missing/extra teeth
Y	N	Pain from Teeth	Y	N	Dental Infection/Abscess
Y	N	Bleeding Gums	Y	N	Stained/discolored teeth
Y	N	Clenching/Grinding Teeth	Y	N	Nursing Bottle Habits
Y	N	Difficulty Swallowing	Y	N	Pacifier
Y	N	Bad breath	Y	N	Thumb/Finger Sucking

Physician's Name:

Physician's Phone #:

Emergency Contact Name:

Emergency Contact Phone Number:

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature: Date:

The Parent of Guardian who accompanies the child is responsible for payment.

Our Office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

Office Use Only

Doctor's Notes: