KID'S CORNER
NORTH SHORE DENTAL GROUP, LLP
450 PLANDOME ROAD
MANHASSET, NEW YORK 11030
Tel: 516-627-3535 Website: www.northshoredentalgroup.com Fax: 516-627-3621

Child's Last Name _____ **First Name**_____ **Middle Name** _____

DOB _____ **Age**_____ **M**_____ **F**_____ **School** _____ **Grade**_____

Responsible Parent Last Name: _____ **First Name:** _____

Address: _____
Street City State Zip Code

Home Phone: _____-_____-_____**Cell**_____-_____-_____**E-mail Address:** _____

SOCIAL SECURITY #: _____-_____-_____ **DOB:** _____/_____/_____

Insured Parent's Name _____**SS #** _____ **DOB** _____

Employer Name: _____ **Phone #:** _____

Insurance Company (if any):_____**Group Number:** _____

(If other than parent)
Person Financially Responsible _____ **Relationship to child** _____

Address _____**City** _____ **State**_____ **Zip** _____ **Phone**_____

SOCIAL SECURITY #: _____-_____-_____ **DOB:** _____/_____/_____

What is Your Child's?

Favorite Sport/Hobby? _____**Favorite Toy?** _____

Favorite Movie? _____**Favorite Book?** _____

Favorite Person _____ **Favorite Character** _____

Whom May We Thank For Referring You? _____

Date of last visit to dentist was? _____**For what treatment?** _____

IS YOUR CHILD REQUIRED TO <u>PREMEDICATE</u> BEFORE APPOINTMENTS?

(CIRCLE ONE): ***YES NO***

If Yes, Describe reason for Premedication: _____

DENTAL HISTORY

	YES	NO
Does your child brush teeth daily?	_____	_____
Has child complained about dental problems?	_____	_____
Experience unhappy dental experiences?	_____	_____
Do you desire complete dental service for your child?	_____	_____
Any mouth habits -thumb sucking, **Nail biting, mouth breathing, nursing bottle** habits, pacifier, etc.?	_____	_____
Any unusual speech habits?	_____	_____
Do you assist child with tooth brushing?	_____	_____
Is dental floss used?	_____	_____
Is fluoride taken in any form?	_____	_____
Any injuries to mouth-teeth-head?	_____	_____
Any lost teeth?	_____	_____
Have missing teeth been replaced?	_____	_____
Orthodontic appliances ever worn?	_____	_____

HEALTH HISTORY

Child's Physician _____

Address _____ **Phone**_____

Date of last physical examination _____ **Results** _____

	Yes	No
Is your child under care of physician now?	_____	_____
Is your child receiving any medication or drugs?	_____	_____
Is there any excessive bleeding when cut?	_____	_____
Has your child ever been hospitalized?	_____	_____
Has your child ever had surgery?	_____	_____
Is there any allergy to penicillin or other drugs?	_____	_____
Are there other allergies: food, pollen, dust, etc.?	_____	_____
Does your child have good physical coordination?	_____	_____
Are there any emotional problems?	_____	_____

HAS CHILD ANY DIFFICULTY WITH ANY OF THE FOLLOWING: (Please write yes or no next to each item)

___ Anemia	**___Chronic Sinus**	**___Hearing**	**___Mastoid**	**___Rheumatic Fever**
___Asthma	**___Convulsions**	**___Heart**	**___Measles**	**___Thyroid**
___Bladder	**___Diabetes**	**___Kidney**	**___Murmur**	**___Tuberculosis**
___Cerebral Palsy	**___Epilepsy**	**___Liver**	**___Mononucleosis**	
___Chicken Pox	**___Fainting**	**___Malignancies**	**___Mumps**	**___Other**

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information I should be aware of that we have not discussed (write none if applicable)

_____

_____

_____

_____

To the best of my knowledge, the foregoing questions have been accurately answered. I grant the right to the dentist to release health information obtained from me, and information about my dental treatment to third party payers, and/or other health practitioners. I give the doctor permission to use any photographs taken for educational and commercial purposes. I also give permission to obtain copies of records and x-rays from my previous dentist(s) Dr. _____.

INSURED PARTIES ONLY: I hereby authorize payment directly to North Shore Dental Group of the group insurance benefits otherwise payable to me. I understand I am financially responsible for any charges not covered by my insurance(s). I authorize release of any information relating to my dental benefits and claims.

_____ Date____/_____/____
Insured's Signature

_____ Date____/_____/_____
Signature of person completing the form

Reviewed by Dr. _____ Date _____/_____/_____