Patient History & Information – Pediatric Dental Examination

Patient Name_____ **Birth Date**_____
Last Name First name Nickname

Home Address_____ **Town**_____ **Zip**_____

Phone _____ _____
Home Cell

Email Address _____@_____ **School Attending** _____

Physician & Phone _____

Has patient had an dental examination before? Where? _____

Have any other family members been seen in this office? Please list. _____

Whom may we thank for referring you to our pediatric dental practice?_____

Parent Information:	**Father**	**Mother**
Full name	_____	_____
Date of Birth	_____	_____
SSN	_____	_____
Occupation	_____	_____
Business Tel	_____	_____

Marital Status of parents (circle): married separated/divorced single

Medical History

Does the patient have or has he/she ever had : (please circle)

Heart murmur / mitral valve prolapse / other heart defects…	Yes	No	Rheumatic fever ……..	Yes	No
Mental Illness……	Yes	No	Nervous disorder……..	Yes	No
Asthma / other respiratory disease……	Yes	No	Bleeding Disorders……..	Yes	No
Anemia……	Yes	No	Allergies……..	Yes	No
Diabetes……	Yes	No	Tuberculosis……	Yes	No
HIV……Yes	No		Convulsions/epilepsy……..	Yes	No
Kidney Disease……	Yes	No	Hepatitis or liver disease……	Yes	No

Is patient allergic to penicillin, aspirin, or any other medication……Yes No

Is patient taking any medication at the present time?..... Yes No

Is patient under medical care now?..... Yes No

Has patient ever had an unfavorable reaction from previous dental or medical care?..... Yes No

Any previous hospitalizations?..... Yes No

Date of last medical examination…….____

Date of last dental examination……____

If any of the above answers are yes, please explain:

I hereby authorize Dr. Richard Shulman DMD to render any services deemed necessary in the dental treatment of _____ after consent by parent.

Date:_____ Signature of parent or guardian_____

The policy in our office is the parent who requests treatment for the child is responsible for all fees for services rendered.

Richard L. Shulman, DMD, PC
Christian E. Miller, DDS
Plainview, NY (516) 932-1101

Dental Insurance Information

Primary Dental Insurance Company

Insurance Company Name: _____

Address: _____
City: State: Zip:

Insurance Company telephone number: _____

Employer: _____

Employer Address:_____
Employer phone number:_____

Insurance Subscriber's Name: _____

DOB ____/____/_____ SS# _____/_____/_____

ID# _____ Group# _____ Local # _____

Family members covered under this plan: _____

School attended Full Time by dependents over age of 19 years Old:_____

Assignment of Benefits
I authorize payment of benefits to Dr Shulman for
Dental services provided.

x_____
Signature Date

Release of Information
I authorize the release of and dental information
Necessary to process claims.

x_____
Signature Date