

PEDIATRIC DENTISTRY AND WEST SIDE ORTHODONTICS, LLC

327 Central Park West
New York, New York 10025
212 280-1700
www.pdwsso.com

Today's Date _____

Patient's Name _____ Age _____ Birthdate _____

Patient's Address _____ Zip Code _____

Names and Ages of Siblings _____

Hobbies, Pets, Nickname _____ School _____

Parent

Date of Birth _____

Name _____ Social Security # _____

Home Address _____ Zip Code _____ Residence Phone _____

Email Address _____ Cell # _____

Occupation _____ Company Name _____ Business Phone _____

Parent

Date of Birth _____

Name _____ Social Security # _____

Home Address _____ Zip Code _____ Residence Phone _____

Email Address _____ Cell # _____

Occupation _____ Company Name _____ Business Phone _____

Marital Status of Parents _____

Family Nanny

Name _____ Cell # _____

WHOM MAY WE THANK FOR REFERRING YOU?

Name _____ Address _____

PAYMENT INFORMATION

Credit Card Name _____ No. _____ Expiration Date _____

Name of Dental Insurance _____ Group and ID # _____

Name of Primary Plan Holder _____ Birthdate _____

Dental Insurance Telephone # _____

Dental Insurance Claims Mailing Address _____ Zip Code _____

NOTE

PDWSO DOES NOT PARTICIPATE WITH ANY DENTAL INSURANCE PLANS. HOWEVER AS A PROFESSIONAL COURTESY WE WILL BILL YOUR DENTAL INSURANCE FOR REIMBURSEMENT.

DENTAL HISTORY

Is this your child's first trip to the dentist?

If no, please give us the date of the last visit and the name of the dentist.

Please tell us why you are here (routine visit, emergency or other immediate concerns) _____

Has your child ever been treated for dental injury, toothache, or other emergency?

How has your child behaved during previous dental treatment (if applicable)? _____

MEDICAL HISTORY

Pediatrician/Physician _____ Address and Phone _____

Please state any medical, emotional, or behavioral condition that your child has or is suspected of having. Please be specific. _____

Does your child take any medication? If so, please state name and dosage if known.

Does your child have any allergies to medication? If so, please state _____

Does your child have any LATEX allergies? If so, please state _____

Does your child have any food or seasonal allergies? If so, please state _____

Have you ever been told that your child has a heart murmur? _____ If yes, do they require antibiotic premedication before a dental visit? _____

PLEASE CHECK ANY CONDITION THAT APPLIES TO YOUR CHILD:

Bleeding Disorders
Heart Disease
Gastro Intestinal Disease
Asthma
AIDS
Seizures

Neurologic Disorders
Urinary Tract Disorders
History of Surgery
Diabetes
Arthritis
Liver Disorders

Kidney Disease
Sickle Cell Disease
Learning Disorders
Possibility of Pregnancy
Blood Transfusions
Premature Birth

SIGNATURE OF PARENT/GUARDIAN _____ RELATIONSHIP _____ DATE _____

The parent/guardian whose signature appears above is responsible for all fees when services are rendered and consents to treatment as explained to them by the dentist or dental professional.