Saavedra
Family Dental, PC

185 N Wantagh Avenue, Levittown, NY 11756 • Phone (516)622-9394 • Fax (516)622-9396

Please fill out both sides of this form as completely as possible.
This information will be of great value in understanding your child to provide them with the best in oral health care

Childs Name_____ _____Nickname_____
First Middle Last
Sex: M___ F___ Birth date_____ Adoption/Guardianship Date (if applicable)_____
What is the reason for today's visit?_____
Is this your child's 1st dental visit?_____ Date of last visit_____ Purpose_____
What is your child's attitude towards previous dental care?_____
Name of child's pet/kind_____ Child's interests_____
What school or pre-school does your child attend?_____
Name of your dentist_____ Child's previous dentist_____
How did you hear about the office?_____

MEDICAL INFORMATION

Child's Pediatrician_____ Phone Number_____
Date of last physical exam_____ Is you child under a doctors care now?_____
For what reason?_____
Is your child taking any medications or drugs?_____ What kind?_____
Reason_____
Has your child ever been hospitalized?_____ When?_____ Why?_____
Is your child allergic to any medications?_____ Please List_____
Reaction_____
Does your child have allergies to: food_____animals_____pollen_____dust_____latex_____
Does your child have good physical coordination?_____
Has your child's developmental milestones been attained?_____
Are your child's immunizations up to date?_____
Has your child had a **history** or **difficulty** with any of the following:

Yes	No		Yes	No		Yes	No	
___	___	High Fevers	___	___	Bleeding Problems	___	___	Hearing Difficulties
___	___	Premature birth	___	___	Nosebleeds	___	___	Earaches (chronic)
___	___	Tuberculosis	___	___	Bruising	___	___	Gag Reflex
___	___	Heart Problems	___	___	Anemia	___	___	Motion Sickness
___	___	Rheumatic Fever	___	___	Hepatitis	___	___	Cancer or Malignancies
___	___	Asthma	___	___	Brain Injury	___	___	Kidney Problems
___	___	Seizures	___	___	Bone Disorder	___	___	Reflux/Regurgitation
___	___	Diabetes	___	___	Cerebral Palsy	___	___	Fainting or Dizziness
___	___	Immune Disorder/HIV/AIDS	___	___	Liver Problems	___	___	Speech Disorders
___	___	Mental/Physical Disabilities				___	___	Chronic Cough/Congestion

Comments/ Details_____
Does your child have phobias?_____ Any emotional or school problems?_____

DENTAL INFORMATION

Was your child bottle fed?_____ Until what age?_____ or breast fed?_____ Until what age?_____

Does your child have oral habits, such as: finger/thumb sucking_____ pacifier_____ nail biting_____ snoring_____

Lip sucking_____ mouth breathing_____ tooth grinding_____ other_____

Has your child ever had any injuries to the teeth, mouth or head?_____ Describe_____

Has your child taken fluoride?_____ In what form and when?_____

Does your child brush regularly?_____ How many times a day?_____ With adult assistance?_____

Does your child use floss?_____ How often?_____ With adult assistance?_____

Has either parent or child been treated orthodontically (braces)?_____

How would you expect your child to behave in our office?_____

Describe your child: Outgoing_____ Shy_____ Stubborn_____ Anxious _____ Frightened_____

How may we help make this a positive experience for your child?_____

THANK YOU FOR COMPLETING THIS DETAILED INFORMATION SO WE MAY BECOME BETTER AQUAINTED WITH YOUR CHILD.

GENERAL INFORMATION

This information is requested for financial and credit purposes.

Name of person financial responsible for this child_____

FATHER (full name)_____ Date of Birth_____ Marital Status_____

Home Address_____ City/ State_____ Zip_____

Employer_____ Address_____ City_____

Social Security #_____ Phone #'s: Home_____ Work _____Cell_____

MOTHER (full name)_____ Date of Birth_____ Marital Status_____

Home Address_____ City/ State_____ Zip_____

Employer_____ Address_____ City_____

Social Security #_____ Phone #'s: Home_____ Work _____Cell_____

Child resides with: Both parents_____ Caregiver_____ Other_____

Name of nearest relative not living with you_____ Relationship_____

Address_____ City/Zip_____ Home #_____ Work#_____

DENTAL INSURANCE INFORMATION

FATHER: Name of Insurance Company_____ Group/ Policy #_____

Address_____ Union Local_____

MOTHER: Name of Insurance Company_____ Group/ Policy #_____

Address_____ Union Local_____

Assignment of Benefits: I hereby authorize payment directly to the above named dentists of the group dental benefits otherwise payable to me but not to exceed the charges shown on the claim. I understand that I am financially responsible for any charges not covered by this authorization.

Consent: I give the dentist permission to use such measures as deemed necessary in his/her professional judgment to render the best dental treatment for my child.

SIGNATURE: _____ Date _____

Relationship to child_____

Saavedra Family Dental, PC

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Saavedra Family Dental to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations (TPO). (The Notice of Privacy Practices provided by Saavedra Family Dental describes such uses and disclosures more completely.)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Saavedra Family Dental reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Saavedra Family Dental at 185 N Wantagh Avenue Levittown, NY 11756 phone (516) 622-9394

With this consent, Saavedra Family Dental may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, Saavedra Family Dental may mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked "Personal and Confidential."

By signing this form, I am consenting to allow Saavedra Family Dental to use and disclose my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Saavedra Family Dental may decline to provide treatment to me.

_____
Signature of Patient or Legal Guardian

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable