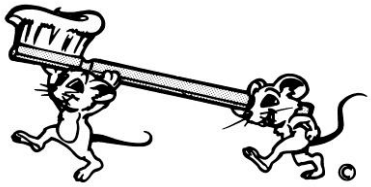

**** Welcome ****

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on comprehensive care focusing on prevention and cosmetics. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Today's date: _____

TELL US ABOUT YOUR CHILD

Child's Name: _____ Nickname: _____
Child's Birth Date _____ Child's Age: _____ Male: _____ Female: _____
School: _____ Grade: _____
Child's Home #: _____ SS#: _____
Child's Address _____ City _____ State: ____ Zip: _____
Whom may we contact in case of emergency? Name: _____ Tel. #: _____
Address: _____ City: _____ State: ____ Zip: _____

WHO IS ACCOMPANYING THE CHILD TODAY?

Name: _____ Relationship to patient: _____
Do you have legal custody of this child? _____ Yes _____ No
Who may we thank for referring you? _____
Address: _____ Phone: _____
Other family members seen by us: _____
Previous/Present Dentist: _____City/State: _____Last Visit Date: _____
Parent's Marital Status: _____ Single _____ Married _____ Widowed _____ Divorced _____ Separated

Preferred method of contact for confirming appointments:
Please circle one: Mother Father Guardian Please circle one: e-mail cell phone

PARENTS' INFORMATION

Mother's Information: _____ Mother _____ Stepmother _____ Guardian
Name: _____ Work #: _____ Home #:_____ Pager/Cell #:_____
Address: _____ City: _____ State: _____ Zip: _____
Employer: _____ DOB: _____ SS#: _____ DL#: _____
Address: _____ City: _____ State: _____ Zip: _____
E-mail address: _____

Father's Information: _____Father _____ Stepfather _____ Guardian
Name: _____ Work #: _____Home #: _____ Pager/Cell# _____
Address: _____City: _____ State: _____ Zip: _____
Employer: _____ DOB: _____ SS#:_____ DL#: _____
Address: _____City: _____State: _____ Zip: _____
E-mail address: _____

DENTAL INSURANCE

Primary Dental Insurance

Insurance Co. Name _____ Ins. Co. Phone #: _____
ID #: _____Group#: _____
Insured's Name: _____ Relationship to patient: _____
Insured's Birthday: _____ Insured's SS#:_____

Secondary Dental Insurance

Insurance Co. Name: _____ Ins. Co. Phone #:_____
ID #: _____Group#: _____
Insured's Name: _____Relationship to patient: _____
Insured's Birthday: _____ Insured's SS#: _____

Why did you bring your child to the dentist today? _____
Has your child ever had a serious / difficult problem associated with previous dental work? _____
If yes, describe: _____
Is your child currently in discomfort? ___ Yes ___ No If yes, describe _____
How long has your child been in discomfort? _____ Has Advil or Tylenol, etc. helped?_____
Does your child drink any of these? ___ Bottled water ___ Tap water ___ Both tap and bottled water
Is your child's water fluoridated? ___ Yes ___ No ___ Unsure
Does your child drink filtered water? ___ Yes ___ No
If yes, is it by reverse osmosis? ___ Yes ___ No
Is your child taking fluoride supplements? ___ Yes ___ No
Does your child take a multivitamin daily? ___ Yes ___ No If yes, what kind?_____
Are your child's teeth brushed daily? ___ Yes ___ No Who brushes your child's teeth?_____
Are your child's teeth flossed daily? ___ Yes ___ No Who flosses your child's teeth?_____
Do you see your dentist regularly? ___ Yes ___ No
What is your dentist's name? _____ City_____

Does your child eat sticky/sugary foods? ___Yes ___ No If yes, how often? _____
Does your child drink carbonated beverages? ___Yes ___ No If yes, how often? _____
Does your child drink juice/sports drinks/vitamin water? ___Yes ___ No If yes, how often? _____

Please indicate if your child does any of the following:

_____ Wakes up at night/ night terrors
_____ Restless sleep
_____ Mouth breathing/ gasping
_____ Tired during the day
_____ Grind/clench teeth
_____ Snores
_____ Slow eater
_____ Bed wetting
_____ Hard to wake up in the morning
_____ Hyperactive

Please indicate if your child has any of the following habits:

____ Thumb/finger sucking ____ Tongue thrust
____ Pacifier use ____ Nail biting

Child's Physician: _____
Phone #: _____ City: _____ Date of last visit: _____
Does your child see a physician regularly (annual exams)? ____ Yes ____ No
Please describe your child's current physical health: ____ Good ____ Fair ____ Poor
Was your child born full term? _____ Yes _____No
Please list any complications during pregnancy or birth: _____

Please list all drugs and supplements (prescription and non-prescription) that your child is currently taking:

_____
_____

My child is not currently taking any drugs or supplements:_____

IS YOUR CHILD ALLERGIC TO OR HAD A REACTION TO ANY OF THE FOLLOWING:

Yes / No	Aspirin	Yes / No	Local Anesthetic	Yes / No	Food: (please list):_____
Yes / No	Codeine	Yes / No	Metal (any type)		_____
Yes / No	Demerol	Yes / No	Penicillin		
Yes / No	Erythromycin	Yes / No	Sulfa Drugs	Yes / No	Other: (please list):_____
Yes / No	Latex	Yes / No	Valium		_____

Describe the allergic reaction:

_____

Please list any drugs (not listed above) that your child is allergic to and describe the reaction:

_____

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS? (Please circle Yes or No)

Yes / No Allergies/hay fever
Yes / No Anemia
Yes / No Abnormal bleeding/hemophilia
Yes / No ADD/ADHD
Yes / No AIDS/HIV
Yes / No Asthma
Yes / No Autism
Yes / No Bruise easily
Yes / No Cancer
Yes / No Canker or cold sores
Yes / No Congenital heart defect
Yes / No Developmental delay
Yes / No Diabetes
Yes / No Eating disorder
Yes / No Excessive thirst
Yes / No Fainting spells/dizziness
Yes / No Family history of diabetes
Yes / No Family history of heart disease
Yes / No Frequent diarrhea
Yes / No Frequent/severe headaches
Yes / No Frequent urination
Yes / No Hearing impairment
Yes / No Heart murmur/heart disease
Yes / No Hepatitis/liver disease/jaundice
Yes / No Hospitalization/surgeries
Yes / No Kidney/bladder disease
Yes / No Nervous/anxiety disorders
Yes / No Persistent cough
Yes / No Rheumatic Fever
Yes / No Seizures/epilepsy
Yes / No Sinus problems
Yes / No Skin disease/eczema/psoriasis
Yes / No Stomach problems /GERD
Yes / No Syndrome (Describe):
_____
_____
Yes / No Thyroid disease/disorder
Yes / No Transplant
Yes / No Tuberculosis
Yes / No Visual impairment/eye disease
Yes / No Other (describe): _____
_____
_____

Does your child have any medical conditions or concerns not on this list? Yes ___ No___
If yes, please describe_____

FOR OUR ADOLESCENT FEMALE PATIENTS:

Date of last period: _____ Are you currently taking birth control pills? ____ Yes ____ No

I understand that the information that I have given is correct to the best of my knowledge, 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 certify that I have read and understand this form. To the best of my knowledge I have answered every question completely and accurately. I will inform my child's dentist of any change(s) in my child's health and/or medication.

I, _____ the parent of _____ hereby agree to allow Joseph Renzi, Jr., D.D.S., Inc to use any and all radiographs and photos for teaching purposes. I understand that there will be no identification of my child and that none of the documents used will allow my child to be identified.

Further, I will not hold my child's dentist, or any member of their staff, responsible for any errors or omissions that I may have made in the completion of this form. I also authorize the dentist and their staff to perform the necessary dental services that I may need. The practice of dentistry involves treating the whole person. If the dentist determines that there may be a potentially medically-compromised situation, medical consultation may be needed prior to commencement of dental treatment. I authorize the dentist to contact my child's physician.

_____ _____
Signature of Parent/Responsible Party **Date**

For Office Use Only

I verbally reviewed the medical/dental information above, with the patient/patient's parent named herein:

Dentist Initials_____ Date: _____

Comments: _____

_____

_____

_____

_____

ASSIGNMENT OF BENEFITS

I hereby authorize payment of the insurance benefits otherwise payable to subscriber directly to Joseph Renzi, Jr., D.D.S. Inc. I understand I am financially responsible for any/all charges not covered by insurance. I authorize release of any/all information necessary for the filing of dental insurance claims.

_____ _____
Signature of Subscriber **Date**

_____ _____
Signature of Secondary Subscriber **Date**