Tooth Fairy World

Marylene Vitiello, D.D.S Pediatric Dentistry

We welcome your child into our practice and we will try to make this dental experience very pleasant. Please complete this form thoroughly because this information is of great value in aiding us to better understand your child.

Patient Information

Child's Name ____ Nick Name_______________________________ Sex __ _ Age _______

Birth Date _________ Place of Birth _________________________ Attends what school______________________________ Grade _____

Name(s) and ages(s) of brothers and sisters ____

Child's physician or pediatrician _ ____

Pediatrician's Address ____ Telephone ______________________

Dental Insurance: Yes __ No __ Father's Insurance __ _ Mother's Insurance ___

Whom may we thank for referring you to our office? ____

Purpose of this visit ____

Name and kind of child's pet, toy, hobbies or sport activity ____

Health History

1). Is your child in good health? ____

2). Was your child a full term infant? ____

3). Is your child up to date with immunizations? ____

4). is your child presently taking medicine? ____

If so, what? ____ Vitamins? ____

5). Has your child had any unfavorable reaction or allergy to drugs, including antibiotics (penicillin) and local anesthetic solution?

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6). Is your child presently undergoing medical treatment? ____

If so, what? ____

7). Has your child had his or her tonsils and/or adenoids removed? ____

8). Has your child been hospitalized since birth? ____

9). Does your child have or has he/she had in the past frequent ear and throat infections or tubes in the ears? _______________________

10). Does your child have any history of hearing loss or speech problems? ____

11). Is your child adopted? ____

12). In your family, is there a history of any malocclusions, bad bites, missing or extra teeth? _____________________________________

If yes, please specify.____

13). Has your child ever had a space maintainer, retainer, braces, orthodontic treatment, dental tooth movement or head/mouth injury?

If yes, please specify. ____

14). Has your child had any unfavorable experiences in a dental or medical office? Please explain.

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15). Has your child had a toothache recently? ____

16). Is this your child's first dental visit ? ____

17). Has your child had any history of thumb sucking, finger sucking or did he/she use a pacifier past 1 ½ years of age?

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18). Is your child still feeding on the bottle or breast? ____

If not, at what age did he/she stop? _______

19). If you have previously completed this for another child please provide the child's name_______________________________________

20). Do you expect your child to come to this office without you, either with a sitter, relative or unattended? ________________________

Please check any of the following that may pertain to your child:

( ) Heart Condition	( ) Infectious Diseases	( ) Brain Injury	( ) Speech Disorder	( ) Emotional Disorder
( ) Rheumatic Fever	( ) Hepatitis	( ) Cerebral Palsy	( ) Hearing Disorder	( ) Asthma
( ) Liver Problem	( ) HIV	( ) Epilepsy	( ) Vision Disorder	( ) Mental Disorder
( ) Lung problem	( ) Tuberculosis	( ) Anemia	( ) Food Allergy	( ) Sensory Issues
( ) Kidney Problem	( ) Bleeding Disorder	( ) Sickle Cell Anemia	( ) Drug Allergy	( ) ADHD / ADD

Parents' Information

Father

Name ____ Address ____ Zip: ________
Birth Date ______________ E-mail ____ SSN _______________
Home Phone ________________________ Cell Phone _______________________ Work Phone ______________________________
Employer ___________ Occupation ____________________________Work Address ____

Mother

Name ____ Address ____
Birth Date ______________ E-mail ____ SSN _______________
Home Phone ________________________ Cell Phone _______________________ Work Phone ______________________________
Employer ___________ Occupation ____________________________Work Address ____
Daytime phone number for confirmation of appointment: ________________ with whom does the patient live: _________________
Person responsible for account: ____________________ In case of emergency, name of the nearest relative or friend ______________
Emergency Phone ________________________________

Each appointment represents a specific amount of time reserved for our child's dental care. If some problem arises so that you are unable to keep this time, we require 48-hour notification for any cancellation. A charge will be made for failed appointments without notification.

Insurance Information

Policy Holder's Name ________________________ Policy Holder's Employer ____
Name of Insurance____ Insurance Phone No._________________________________
Group/Plan No. _________ Do you have Dual Coverage? _____ Name of Secondary Ins. ___________________________________
Secondary Insurance Group No. _____________

To avoid misunderstanding regarding dental insurance, we wish the person responsible to know that professional services are charged directly to them and not their insurance company. We will bill your insurance for you as a courtesy. We do not "re-bill" insurance companies after 60 days from the date of service. All unpaid balances greater than 60 days become the parent's responsibility. Delinquent accounts over 120 days may be turned over to collection agency. *No future well care dental visits will be scheduled until open balances are paid in full.* Because your child is a minor, it becomes necessary that a signed permission be obtained from a parent or guardian before any necessary dental treatment is performed. The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental treatment and the use of those methods appropriate thereto. This consent shall remain in force and effective until cancelled by either party. Furthermore, the signee will be responsible for any bill incurred during this child's dental treatment.

Signature ____ Date ______________________