Tooth Fairy World, PC (Hyde Park) - 11/1/2023

Patient Information

Patient Information

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

Child's Name	Nick Name	Gender	Age
Birth Date	Place of Birth	Attends what school	Grade
Name(s) and age(s) of brothers and sisters		Pediatrician's name and address	
Telephone			

Dental Insurance

Dental Insurance	Father's Insurance	Mother's Insurance

Additional Information

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

Medical History

Is your child in good health?	Was your child a full term infant?	Is your child up to date with immunizations?	Is your child presently taking medicine?
Is your child presently taking vitamins?	Has your child had any unfavorable reaction or allergy to drugs, including antibiotics (penicillin) and local anesthetic solution?	Is your child presently undergoing medical treatment?	Has your child had his or her tonsils and/or adenoids removed?
Has your child been hospitalized since birth?	Does your child have or has he/she had in the past frequent ear and throat infections or tubes in the ears?	Does your child have any history of hearing loss or speech problems?	Is your child adopted?
In your family, is there a history of any malocclusions, bad bites, missing or extra teeth?	Has your child ever had a space maintainer, retainer, braces, orthodontic treatment, dental tooth movement or head/mouth injury?	Has your child had any unfavorable experience in a dental or medical office?	Has your child had a toothache recently?
Is this your child's first dental visit?	Has your child had any history of thumbsucking, fingersucking or did he/she use a pacifier past 1 ½ years of age?	Is your child still feeding on the bottle or breast?	

If you have previously completed this for another child, please provide the child's name.	Do you expect your child to come to this office without you, either with a sitter, relative or unattended?

Health Conditions

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

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

Parents' Information

Father's Information

Name			
Address			
Birth Date	E-mail	SSN	Home Phone
Cell Phone	Work Phone	Employer	Occupation
Work Address			

Mother's Information

Name			
Address			
Birth Date	E-mail	SSN	Home Phone
Cell Phone	Work Phone	Employer	Occupation
Work Address			

Parental Information

Daytime phone number for confirmation of appointment	With whom does the patient live?
Person responsible for account	
Emergency Contact	
In case of emergency, name of the nearest relative or friend	Emergency Phone

Appointment Policy

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 24-hour notification for any cancellation. A charge will be made for failed appointments without notification.

Insurance Information

Insurance Information

Is the child covered by dental insurance?

Policy Holder's Name	Policy Holder's Employer	Name of Insurance
Insurance Phone No.	Group/Plan No.	Does the child have dual coverage?
Name of Secondary Insurance	Secondary Insurance Group/Plan 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 fall. 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

Signature

Date

Thank you!

Thank you!

Thank you for filling out the questionnaire, please preview your dentist's profile and the office location prior to your visit.

We look forward to seeing you soon!