Tooth Fairy World
PEDIATRIC DENTISTRY & ORTHODONTICS
MARYLENE VITIELLO, DDS

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?
_____
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.
_____
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?
_____
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 _____