Pediatric Dentistry & Family Orthodontics

Andrew M. Arcuri, DDS, MS
Michael B. Quigley, DDS
Michael J. Weinstein, DDS
Young H. Son, DMD
Derek P. Nguyen, DDS

5538 North Burdick Street
Fayetteville, NY 13066

www.pediatricdent.com

Phone: (315) 637-6961
Fax: (315) 637-0169

Building Smiles, Faces, & Self-Esteem the Fun, Gentle, & Easy Way

PATIENT INFORMATION

Child's Last Name_____ **First Name**_____
Physical Address_____ City _____
State _____ Zip Code _____ Home Phone_____
Gender: ( )M ( )F Date of Birth_____ Soc. Security #_____
Nickname _____Favorite Interests/Hobbies_____

PARENT INFORMATION

( ) Biological/Adoptive Parent #1 ( ) M or ( ) F **OR** **( )*Legal Guardian** ( ) M or ( ) F
***Must provide our office with the appropriate court issued paperwork showing legal guardianship.**

Last Name_____ First _____
Physical Address _____
Mailing Address **(If different)** _____
Cell Phone_____ Alternate Phone _____
Business Phone _____ E-mail address _____
Name of Employer _____ Occupation _____
Date of Birth _____Soc. Security#_____

Marital Status: ( ) Married ( )Single ( )Separated ( )Divorced ( ) Widowed ( ) Significant Other

( )Biological/Adoptive Parent #2 ( )M or ( )F **OR** **( ) *Legal Guardian** ( )M or ( )F
***Must provide our office with the appropriate court issued paperwork showing legal guardianship.**

Last Name_____ First _____
Physical Address _____
Mailing Address **(If different)** _____
Cell Phone_____ Alternate Phone _____
Business Phone _____ E-mail address _____
Name of Employer _____ Occupation _____
Date of Birth _____Soc. Security#_____

Marital Status: ( ) Married ( )Single ( )Separated ( )Divorced ( ) Widowed ( ) Significant Other

Does the child reside with: ( ) Both parents ( ) Parent #1 ( ) Parent #2 ( ) ***Legal Guardian**
***Must provide our office with the appropriate court issued paperwork showing legal guardianship.**
Is there a custody arrangement? ( ) No ( )* Yes
***If "yes" and the office needs to be aware of any stipulations regarding custody, you must provide us with a copy of the court issued paperwork for your child's record.**

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

Are there any siblings that come to our office? ( )Yes ( ) No if yes, please list names _____
If you only receive orthodontic care at our office, who is your dentist of record? _____

When possible, we try to confirm appointments as a courtesy. Please tell us where you would like your appointment confirmed?
( ) Home phone ( ) Work phone ( ) Cell phone ( ) Email

Signature of Legally Responsible Parent/Guardian

_____ _____ _____
Signature **Date** **Print Name**

_____ _____ _____
Signature **Date** **Print Name**

INSURANCE AND FINANCIAL INFORMATION

INSURANCE INFORMATION

Dental Insurance Information

Primary Insurance
Insured's Name_____
Relationship to patient _____D.O.B._____
Soc. Security#_____
Employer_____
Insurance Co._____
Insurance ID#_____
Group#_____ Employee #_____
Insurance Co. Address_____
_____
Insurance Co. Phone#_____

Secondary Insurance
Insured's Name _____
Relationship to patient _____D.O.B. _____
Soc. Security#_____
Employer_____
Insurance Co. _____
Insurance ID#_____
Group# _____ Employee#_____
Insurance Co. Address_____
_____
Insurance Co. Phone#_____

Medical Insurance Information

Primary Insurance
Insured's Name_____
Relationship to patient _____D.O.B._____
Soc. Security#_____
Employer_____
Insurance Co._____
Insurance ID#_____
Group#_____ Employee #_____
Insurance Co. Address_____
_____
Insurance Co. Phone#_____

Secondary Insurance
Insured's Name _____
Relationship to patient _____D.O.B. _____
Soc. Security#_____
Employer_____
Insurance Co. _____
Insurance ID#_____
Group# _____ Employee#_____
Insurance Co. Address_____
_____
Insurance Co. Phone#_____

FINANCIALLY RESPONSIBLE INFORMATION

Financially Responsible Party:

( ) Father ( ) Mother ( ) Legal Guardian ( )Other, please list_____

Last Name_____ First_____
Mailing Address_____ City_____ State_____ Zip _____
Home Phone _____ Cell Phone_____ Business Phone _____
Alternate Phone_____ E-Mail Address _____
Driver's License#_____ Soc. Security#_____

Signature of Financially Responsible Parent/Guardian

I am aware that payment is expected at the time services are rendered. I agree to pay Pediatric Dentistry and Family Orthodontics at the time of service for any/all services. Any service charges, collection or legal fees which arise from my failure to pay for services rendered will be paid by the financially responsible party.

_____ _____ _____
Signature **Date** **Print Name**

_____ _____ _____
Signature **Date** **Print Name**

PATIENT DENTAL HISTORY

	Yes	No		Yes	No
Any injuries to the mouth?	☐	☐	Do you have fluoridated water?	☐	☐
Using a bottle?	☐	☐	Is fluoride taken in any other form?	☐	☐
Bottle used in bed?	☐	☐	Does child brush 2 times per day?	☐	☐
Any unhappy dental visits?	☐	☐	Do you supervise brushing?	☐	☐

	Yes	No	If "Yes" please explain
Grinding of teeth?	☐	☐	_____
TMJ (jaw joint) problems?	☐	☐	_____
Is there a family history of dental issues? (Ex. Missing teeth, extra teeth, etc.)	☐	☐	_____
Are there any dental concerns today?	☐	☐	_____

Were you referred for orthodontic reasons or do you have any smile or bite concerns? ☐Yes ☐ No If "yes" please explain_____

_____

PLEASE CHECK IF YOUR CHILD HAS A HISTORY OF ANY OF THE FOLLOWING:

☐ Thumb sucking ☐ Finger sucking ☐ Pacifier habit ☐ Mouth Breather ☐ Snoring ☐ Sleep apnea

PATIENT MEDICAL HISTORY

Please list all of your child's Medical Professionals:

Name of Physician/Pediatrician _____ Phone _____
Address _____ City _____ Zip code_____
Date of Last Examination_____

Name of Specialist(s) _____ Specialty _____
Address _____ City _____ Zip Code _____
What does this doctor treat your child for? _____ Date of Last Examination _____

Name of Specialist(s) _____ Specialty _____
Address _____ City _____ Zip Code _____
What does this doctor treat your child for? _____Date of Last Examination _____

Does your child or family have a history of MTHFR gene mutation? ( )No ( )Yes If yes, who has the mutation? _____

PLEASE CHECK IF YOUR CHILD HAS A HISTORY OF ANY OF THE FOLLOWING, IF YES PLEASE LIST AN EXPLANATION:

	Yes	No	
Hospitalization or surgery?	☐	☐	_____
Taking any medications or drugs?	☐	☐	_____
History of a heart murmur?	☐	☐	_____
History of prolonged bleeding ?	☐	☐	_____

PLEASE CHECK IF YOUR CHILD HAS A HISTORY OF ANY OF THE FOLLOWING, IF YES PLEASE LIST AN EXPLANTION:

	YES	NO	
Allergic to penicillin?	☐	☐	_____
Allergic to any other medications or foods?	☐	☐	_____
Any other allergies such as latex?	☐	☐	_____
Is currently under the care of a physician for for any reason?	☐	☐	_____
Being exposed to second hand smoke?	☐	☐	_____

PLEASE CHECK IF YOUR CHILD HAS/HAD ANY HISTORY OF THE FOLLOWING:

	Yes	No		Yes	No		Yes	No		Yes	No
Acid Reflux	☐	☐	Cerebral Palsy	☐	☐	Hepatitis	☐	☐	Premedicate	☐	☐
ADD	☐	☐	Chicken Pox	☐	☐	HIV/AIDS	☐	☐	Rett's Disorder	☐	☐
ADHD	☐	☐	Cleft Palate	☐	☐	Kidney Problems	☐	☐	Rheumatic Fever	☐	☐
Anemia	☐	☐	Diabetes	☐	☐	Lactose Intolerant	☐	☐	Seasonal Allergies	☐	☐
Asperger's Disorder	☐	☐	Disabilities	☐	☐	Liver Disease	☐	☐	Seizures	☐	☐
Asthma	☐	☐	Down Syndrome	☐	☐	Measles	☐	☐	Shunts/Prostheses	☐	☐
Autism Spectrum Disorder	☐	☐	Epilepsy	☐	☐	Mentally Disabled	☐	☐	Special Needs	☐	☐
Behavior Problems	☐	☐	Fainting Spells	☐	☐	Mononucleosis	☐	☐	Speech Issues	☐	☐
Bi-Polar Disorder	☐	☐	Feeding Tube	☐	☐	Mumps	☐	☐	STD	☐	☐
Cancer	☐	☐	Grind Teeth	☐	☐	Non-verbal	☐	☐	Thyroid Disease	☐	☐
CDD	☐	☐	Hearing Problems	☐	☐	PDD-Please Specify	☐	☐	Tuberculosis	☐	☐
Celiac Disease	☐	☐	Heart Defect	☐	☐	PDD-NOS	☐	☐	Wheel Chair	☐	☐

If "Yes" to any of the above, please give a short explanation: _____

_____

Pre-medication prior to dental appointments? ☐ Yes ☐ No If yes, please explain why _____

_____

Please describe/list any **current medical conditions not listed above, any current medical treatments, pending surgeries, recent injuries, special needs**, or any other information that we should be aware of?

_____

_____

_____

MEDICATIONS

Please list all medications with dosage and regimen, the related medical condition that it is being taken for, and the name of the physician that prescribes it.

Medication, dosage, regimen	Medical condition	Physician who prescribes
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ACKNOWLEDGEMENT AND AUTHORIZATION

I have answered the above questions to the best of my knowledge. I acknowledge and understand that it is my responsibility to inform the dental office of any changes or updates regarding my child's health or any personal information. I authorize Pediatric Dentistry and Family Orthodontics to perform any necessary dental services that my child might need.

_____	_____	_____
Signature of Legally Responsible Parent/Guardian #1	**Date**	**Print Name**
_____	_____	_____
Signature of Legally Responsible Parent/Guardian #2	**Date**	**Print Name**