



Pediatric Dentistry & Family Orthodontics

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

8016 E. Genesee 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 _____

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 _____

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

PATIENT DENTAL HISTORY

	Yes	No		Yes	No
Any injuries to the mouth?	<input type="checkbox"/>	<input type="checkbox"/>	Do you have fluoridated water?	<input type="checkbox"/>	<input type="checkbox"/>
Using a bottle?	<input type="checkbox"/>	<input type="checkbox"/>	Is fluoride taken in any other form?	<input type="checkbox"/>	<input type="checkbox"/>
Bottle used in bed?	<input type="checkbox"/>	<input type="checkbox"/>	Does child brush 2 times per day?	<input type="checkbox"/>	<input type="checkbox"/>
Any unhappy dental visits?	<input type="checkbox"/>	<input type="checkbox"/>	Do you supervise brushing?	<input type="checkbox"/>	<input type="checkbox"/>
	Yes	No	If "Yes" please explain		
Grinding of teeth?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
TMJ (jaw joint) problems?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Is there a family history of dental issues? (Ex. Missing teeth, extra teeth, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Are there any dental concerns today?	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Were you referred for orthodontic reasons or do you have any smile or bite concerns?	<input type="checkbox"/>	<input type="checkbox"/>	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** _____

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

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

	Yes	No	
Hospitalization or surgery?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Taking any medications or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of a heart murmur?	<input type="checkbox"/>	<input type="checkbox"/>	_____
History of prolonged bleeding ?	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

	YES	NO	
Allergic to penicillin?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic to any other medications or foods?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Any other allergies such as latex?	<input type="checkbox"/>	<input type="checkbox"/>	_____
Is currently under the care of a physician for any reason?	<input type="checkbox"/>	<input type="checkbox"/>	_____

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

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

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