Philip F. Jiamachello, D.D.S. Pediatric Dentistry

NEW PATIENT INFORMATION

Child's Full Name: _____ Name Called By: _____

Date of Birth___/___/____ Age: _____ Sex: Male or Female (Circle) Place of Birth: _____

Street Address: _____City: _____State:____ Zip: _____

Home Phone: _____ SSN: _____-_____-_____

Name of School/Day Care _____

Siblings (Names and Ages) _____

Child Physician _____ Phone _____

Address _____ Date of Last Exam _____

Weight _____ Height _____

PARENT/GUARDIAN INFORMATION

Parent/Legal Guardian: _____

Relation to patient: _____ Employer: _____

Work #:_____ Mobile #:_____

Date of Birth ___/___/____ SSN: _____-_____-_____

Parent/Legal Guardian: _____

Relation to patient: _____ Employer: _____

Work #:_____ Mobile #:_____

Date of Birth ___/___/____ SSN: _____-_____-_____

Email Address: _____

HOW DID YOU HEAR ABOUT OUR OFFICE? □ Website □Phone Book □Dental Office □Pediatrician □Other _____

EMERGENCY CONTACT (Friend or Relative Not Living With You)

Name: _____ Relationship: _____

Home Phone: _____Work Phone: _____ Mobile: _____

CONSENT TO TREATMENT

I authorize the rendering of diagnostic and treatment procedures, including fluoride and local anesthesia by Dr. Jiamachello and dental staff that in their professional judgement may be deemed necessary or beneficial. However, prior to completing treatment, the proposed treatment plan will be presented and discussed with the parent or guardian. The American Academy of Pediatric Dentistry recommends fluoride be applied twice per year to aid in formation of tooth enamel, to repair early stages of tooth decay, and to prevent decalcification. For these reasons, please be aware that this will be applied at each cleaning unless otherwise notified. I further understand that this consent will remain in effect until such time that I choose to terminate.

Signature of Parent/Guardian: _____ Date: _____

DENTAL HISTORY

What is the reason for your child's dental visit? _____

□ Yes □ No Has your child ever been to the dentist? Date of last cleaning & x-rays (if taken) _____

Name of previous dentist: _____Phone: _____

□ Yes □ No Any Injuries or surgeries to mouth, teeth or head?

If Answered Yes Please Explain: _____

□ Yes □ No Does your child suck a finger, thumb, or pacifier (Please circle)? If so, when? _____

□ Yes □ No Does your child go to bed with a bottle or sippy cup? If so, what is in it? _____

□ Yes □ No Does your child snack frequently? What are their favorite snack foods? _____

□ Yes □ No Does your child brush daily? How often? Assisted or Unassisted? _____

□ Yes □ No Any Floss being used? How Often? _____

□ Yes □ No Does your child receive fluoride? If yes how is it received, Water Supply, Dentist, Toothpaste, Vitamins, Tablets or Other? _____

MEDICAL HISTORY

Does your child currently have/previously had any of the following health problems?

□ Yes □ No Allergies (Latex, Penicillin, Eggs, Nuts, Foods, Drug,

Unknown) If yes please list _____ □ Yes □ No Glandular of Hormonal Problems

_____ □ Yes □ No Diabetes/Blood Sugar Problems

□ Yes □ No Rheumatic Fever/Rheumatic Heart Disease □ Yes □ No Arthritis or Rheumatism (Painful, swollen joints)

□ Yes □ No Congenital Heart Disease or Heart Murmur □ Yes □ No Anemia or Blood Disorders

If yes, Premed Needed? _____ □ Yes □ No Asthma or Hay Fever

Name of Pharmacy _____ □ Yes □ No High/Low Blood Pressure

□ Yes □ No Blood Transfusion □ Yes □ No Liver Problems, Jaundice or Hepatitis

□ Yes □ No Any Prolonged Bleeding/Bruises Easily □ Yes □ No Psychological or Emotional Problems

□ Yes □ No Kidney or Bladder Problems □ Yes □ No Seizures

□ Yes □ No Tuberculosis or Pneumonia □ Yes □ No Speech Learning or Hearing Disorders

Please list any current medications: _____

Does your child have any special needs or special circumstances? (i.e. Autism, Cerebral Palsy, Down Syndrome) _____

_____

I hereby certify that all of the above information is correct and true. Because the above named child is a minor, it is necessary that a signed permission is obtained from the parent or guardian before any and/or all necessary dental treatment can be completed. Furthermore, I will be responsible for all charges whether or not covered by insurance. All balances over 30 days are subject to additional finance charges.

Signed _____ Date _____ Relationship to Patient_____