WELCOME

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Barry S. Pinsky, D.D.S. **Ellen B. Folbe, D.D.S.**
and Associates

CHILD'S INFORMATION

Patient Last Name _____ First _____ Initial _____
Nickname _____ (❑ Male ❑ Female) Birthday: Month _____ Day _____ Year _____
Address _____ City _____ State _____ Zip _____
Telephone (Home) _____ (Work) _____
Full time student? ❑ Yes ❑ No School _____
ID# _____ Employer _____

YOUR INFORMATION

Last Name _____ First _____ Initial _____
Address _____
City _____ State _____ Zip _____
Telephone (Home) _____ (Work) _____ (Cell) _____
Employer _____ Soc. Sec. No. _____
Dental Insurance Co. _____ Group & ID # _____
Birthdate _____ Driver's Lic. # _____

Has any member of your family ever been treated in our office? ❑ Yes ❑ No

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

MEDICAL HISTORY

Name of your physician_____ Phone No. _____

Date of Last Physical Examination _____

Are you currently being treated for any medical condition?_____

If so, for what?_____

Has Your Child Ever Been Treated For or Diagnosed With Any of the Following:

Heart Murmur	YES	NO	Heart Surgery/Pacemaker	YES	NO
Anemia	YES	NO	Abnormal Heart Condition	YES	NO
Diabetes	YES	NO	High/Low Blood Pressure	YES	NO
Epilepsy/Seizures	YES	NO	Tendency to Bleed	YES	NO
Hepatitis	YES	NO	Replacement Surgery	YES	NO
Rheumatic Fever	YES	NO	Chest Pain on Exertion	YES	NO
Tuberculosis	YES	NO	Kidney Treatment	YES	NO
Rheumatism/Arthritis	YES	NO	Cancer Treatment	YES	NO
Sinus Trouble	YES	NO	Injury to Face or Jaw	YES	NO
Frequent or severe headaches	YES	NO	Tendency to Faint	YES	NO
HIV + /(AIDS)	YES	NO	Does Your Child Have Any Allergies to:		
Herpes	YES	NO	Local Anesthetic	YES	NO
Asthma	YES	NO	Medication or Drugs	YES	NO
Artificial Heart Valves	YES	NO	Penicillin	YES	NO
Heart Attack/Stroke	YES	NO	Latex	YES	NO

Has your child ever used tobacco products?_____

If allergies to medication or drugs, indicate which ones _____

Is your child taking any medications?_____ If so, which ones _____

Last date of your child's cleaning and examination _____

Does he/she have difficulty chewing food?_____ Does his/her jaw click when chewing? _____

Tender or bleeding gums?_____ Does your child grind or clench his/her teeth during the day or night? _____

Difficulty opening mouth as wide as he/she would like?_____ Sensitive teeth? _____

Tender or bleeding tissue?_____ Are you interested in orthodontic treatment for your child? _____

Authorization

NOTE: Both doctor and patient are encouraged to discuss any and all relevant patient health issues prior to treatment.
I certify that I have read and understand the above and that the information given on this form is accurate. I understand the importance of a truthful health history and that my dentist and his/her staff will rely on this information for treating me. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold my dentist, or any other member of his/her staff, responsible for any action they take or do not take because of errors or omissions that I may have made in the completion of this form. I hereby authorize the attending dentist to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. I authorize the release of information related to patient treatment, payment, or health care operations.

Signature of Patient/Legal Guardian: _____ Date: _____

Signature of Dentist: _____ Date: _____

Please note that you are responsible for the payment of charges not covered by insurance.
A fee of $35.00 will be charged for each returned check.

PRIVACY NOTICE TO OUR PATIENTS

Privacy Notice is available at your request. This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

Signature _____