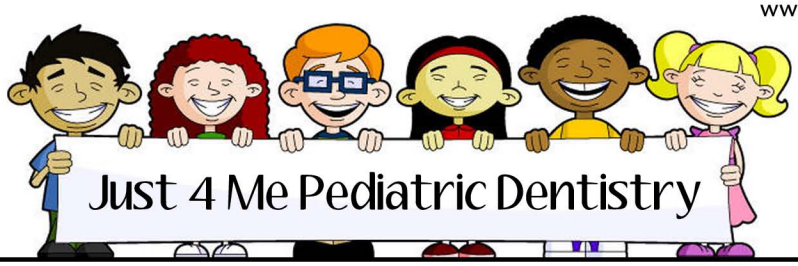
1660 Hopkins Road Suite 107
Getzville, New York 14068
(716) 688-7721
www.just4mepediatricdentistry.com



Tell Us About Your Child

Todays Date: _____ Name/Age of Child's Siblings: _____

Child's Name: _____ Child's Home Address: _____

Nickname: _____ ☐ Male ☐ Female City: _____ State: _____ Zip: _____

Child's Birthdate: _____ Child's Age: _____

Last Dental Visit Date: _____

School: _____ Grade: _____

How did you hear about our office? ☐ Advertisement ☐ Mailer
☐ Friend _____
☐ Physician _____
☐ Other _____

Who is responsible for the child?

Does someone other than a parent have legal custody? ☐ Yes ☐ No
If so, who?
Name: _____ Address: _____

Phone: _____ Relation to child: _____

Who is financially responsible for the child?

Is someone other than a parent financially responsible for the child?
☐ Yes ☐ No
If so, who is?
Name: _____ Address: _____

Phone: _____ Relation to child: _____

Mother's Information:

☐ Stepmother
☐ Guardian

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

E-mail: _____

Employer: _____ Occupation: _____

Work #: _____ SS #: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated

Father's Information:

☐ Stepfather
☐ Guardian

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell: _____

E-mail: _____

Employer: _____ Occupation: _____

Work #: _____ SS #: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated

Dental Insurance Information

Insurance Company: _____ Secondary Insurance: Y N Name: _____

Address: _____ Address: _____

Phone: _____ Group #: _____ Phone: _____ Group #: _____

Local #: _____ Policy #: _____ Local #: _____ Policy #: _____

Primary Person on this Policy: _____ Primary Person on this Policy: _____

Date of Birth: _____ SS #: _____ Date of Birth: _____ SS #: _____

Any Dental Concerns?

_____

_____

_____

Please continue on back of form

Medical History

Does your child currently have or have history of any of the following:

Y	N	Heart Murmur	Y	N	Abnormal Bleeding	Y	N	Convulsions / Epilepsy	Y	N	Overnight Hospital Stay
Y	N	Congenital Heart Defect	Y	N	Hemophilia	Y	N	Kidney / Liver Problems	Y	N	Any Operations
Y	N	Rheumatic Fever	Y	N	Diabetes	Y	N	HIV+ / AIDS			
Y	N	Hepatitis	Y	N	Asthma	Y	N	Cancer			
Y	N	Blood Transfusion	Y	N	Tuberculosis	Y	N	Handicaps / Disabilities			

If yes to any of the above, please explain: _____

Does your child have any disease, condition or problem not listed above that you think we should know about? _____

_____

Has your child ever had an adverse reaction or allergy to a specific medication, food or dye? ☐ Yes ☐ No

If yes, please list: _____

Child's Physician: _____ Phone #: _____

Is your child taking any medications? ☐ Yes ☐ No

If yes, please list: _____

Dental History

Previous Dentist: _____ Location: _____

Phone Number: _____ Date of last X-Rays taken: _____

Has your child ever had a bad experience associated with a dental visit?

_____

Has your child ever suffered from any of the following dental problems?

Y	N	Bad Breath	Y	N	Dental Infection or Abscess
Y	N	Bleeding Gums	Y	N	Pain from Teeth
Y	N	Discolored Teeth	Y	N	Missing or Extra Teeth
Y	N	Cold Sores or Fever Blisters	Y	N	Injury or Trauma to Teeth

Has your child ever had any pain/tenderness in their jaw joint (TMJ / TMD)? ☐ Yes ☐ No

Does your child brush their teeth daily? ☐ Yes ☐ No

Does you child have any of the following habits?

Y	N	Thumb / Finger Sucking
Y	N	Lip Sucking / Biting
Y	N	Nail Biting
Y	N	Nursing Bottle Habits / Pacifier
Y	N	Other _____

Our Office is committed to meeting or exceeding the standards of infection control and sterilization mandated by OSHA, the CDC and the ADA. We are also HIPPA Compliant.

Emergency Contact

In case of an emergency where neither parent nor legal guardian can be reached, please provide whom we may contact.

Name: _____ Relation to child: _____

Phone: _____

To the best of my knowledge, the information that I have provided is correct. I understand that all this information will be confidential. I also understand that it is my responsibility to inform Just 4 Me Pediatric Dentistry of any changes in my child's medical history.

I authorize Dr. Marti Peterson and staff to provide all dental treatments as deemed necessary. I understand that Just 4 Me Pediatric Dentistry cannot gaurantee what my insurance will cover and that I am financially responsible for all services rendered. I am also aware that payment is expected at time of service.

_____

Signature of parent or guardian Date

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

Medical History Update

1. Date: _____ Signature: _____

Comments: _____

_____

_____

2. Date: _____ Signature: _____

Comments: _____

_____

_____