

Patients full name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_ Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Sex: M F

Parent (Name in full): \_\_\_\_\_ M F Parent (Name in full): \_\_\_\_\_ M F  
Residence Address: \_\_\_\_\_ Residence Address: \_\_\_\_\_  
City: \_\_\_\_\_ Zip: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_  
Residence Phone: (\_\_\_\_) \_\_\_\_\_ Residence Phone: (\_\_\_\_) \_\_\_\_\_  
Cell Phone: (\_\_\_\_) \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_  
E-mail Address: \_\_\_\_\_ E-mail Address: \_\_\_\_\_  
Employed by: \_\_\_\_\_ Employed by: \_\_\_\_\_  
Business Phone: (\_\_\_\_) \_\_\_\_\_ Business Phone(\_\_\_\_) \_\_\_\_\_  
Occupation: \_\_\_\_\_ Occupation: \_\_\_\_\_  
\*Driver's License Number: \_\_\_\_\_ \*Driver's License Number: \_\_\_\_\_  
SS #: XXX-XX-\_\_\_\_ Birthdate: \_\_\_\_\_ SS #: XXX-XX-\_\_\_\_ Birthdate: \_\_\_\_\_

Patient's Physician: \_\_\_\_\_ City: \_\_\_\_\_

\*Referred by: \_\_\_\_\_

Former Dentist: \_\_\_\_\_ Orthodontist: \_\_\_\_\_

List children in family who are patients here: \_\_\_\_\_

Dental Insurance Yes \_\_\_\_\_ No \_\_\_\_\_ Carrier: \_\_\_\_\_

Has your child ever been hospitalized? \_\_\_\_\_ Medications: \_\_\_\_\_

Has your child ever had/ have/ been diagnosed with any of the following conditions or had an adverse reaction to any of the following? If yes, please check.

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Allergy- Food Color       | <input type="checkbox"/> Allergy – Latex       | <input type="checkbox"/> Allergy – Local Anesthetic |
| <input type="checkbox"/> Allergy – Penicillin      | <input type="checkbox"/> Allergy – Sulfa Drug  | <input type="checkbox"/> Allergy – Erythromycin     |
| <input type="checkbox"/> Anemia – Sickle Cell      | <input type="checkbox"/> Anemia                | <input type="checkbox"/> Arthritis                  |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Behavior – Anxiety    | <input type="checkbox"/> Behavior – Autism          |
| <input type="checkbox"/> Behavior – Language Delay | <input type="checkbox"/> Behavior – OCD        | <input type="checkbox"/> Behavior - PDD             |
| <input type="checkbox"/> Behavior – Psych. Care    | <input type="checkbox"/> Behavior – Tourette   | <input type="checkbox"/> Behavior – ADHD or ADD     |
| <input type="checkbox"/> Behavior – Depression     | <input type="checkbox"/> Bleeding Disorder     | <input type="checkbox"/> Blood Disease              |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Celiac Disease        | <input type="checkbox"/> Cerebral Palsy             |
| <input type="checkbox"/> Chemo Treatment           | <input type="checkbox"/> Cleft Lip or Palate   | <input type="checkbox"/> Crohns / Colitis           |
| <input type="checkbox"/> Cystic Fibrosis           | <input type="checkbox"/> Diabetes Type 1       | <input type="checkbox"/> Diabetes Type 2            |
| <input type="checkbox"/> Dialysis                  | <input type="checkbox"/> Down Syndrome         | <input type="checkbox"/> Epilepsy                   |
| <input type="checkbox"/> Febrile Seizures          | <input type="checkbox"/> Hearing Disability    | <input type="checkbox"/> Heart Condition            |
| <input type="checkbox"/> Heart Murmur – Premed     | <input type="checkbox"/> Heart Murmur – Benign | <input type="checkbox"/> Hepatitis A                |
| <input type="checkbox"/> Hepatitis B               | <input type="checkbox"/> Hepatitis C           | <input type="checkbox"/> HIV                        |
| <input type="checkbox"/> Kidney Disease            | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Mouth Ulcers               |
| <input type="checkbox"/> Prosthetic – Joint(s)     | <input type="checkbox"/> Prosthetic – Limb(s)  | <input type="checkbox"/> Prosthetic – Other         |
| <input type="checkbox"/> Radiation Treatment       | <input type="checkbox"/> Respiratory Problems  | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Sensitive to Light        | <input type="checkbox"/> Sensitive to Noises   | <input type="checkbox"/> Sensitive to Touch         |
| <input type="checkbox"/> Stomach Problems          | <input type="checkbox"/> Stroke                | <input type="checkbox"/> Surgery – Adenoids         |
| <input type="checkbox"/> Surgery – Ear Tubes       | <input type="checkbox"/> Surgery – Heart       | <input type="checkbox"/> Surgery - Other            |
| <input type="checkbox"/> Surgery – Tonsils         | <input type="checkbox"/> TB “+” Skin Test      | <input type="checkbox"/> TB                         |
| <input type="checkbox"/> Unlisted                  | please specify: _____                          |   |

**Medical Consent:**  
To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has a change in his/her health or medications, I will inform the dentist at the next appointment. My signature below is my consent for treatment of the above mentioned child.

**Insurance Authorization:**  
I consent to your use and disclosure of my protected health information to carry out payment activities in connection with my dental insurance claims. I authorize and direct payment of the dental benefits otherwise payable to me, directly to Lasky Pediatric Dental Group.

**Insurance Policy:**  
We will be happy to bill your dental insurance company for treatment completed, but please remember that YOU are responsible for any balance your insurance company does not pay. We are not an HMO or PPO insurance contracted office, and are considered “OUT OF NETWORK”.

**Financial Responsibility:**  
The parent or guardian of the child who sets up the account will be considered head of household and financially responsible for payment of treatment rendered.

**Financial Policy:**  
The policy of this office limits accounts to 30 days (insurance and terms excepted) without a late payment charge of 1.5% or 18% APR.

**Appointment Policy:**  
We reserve the right to charge for appointments cancelled or broken without a 24 hour notice.

Signature \_\_\_\_\_ Relationship \_\_\_\_\_ Date: \_\_\_\_\_