



OLD GREENWICH DENTAL ASSOCIATES

182 SOUND BEACH AVENUE, OLD GREENWICH, CONNECTICUT 06870

Name of Responsible Party: _____ Relationship to Child: _____
(First/Last)

Mailing Address: _____ City: _____ State: _____ Zip: _____

Sex: M F Age: _____ Birth date: ____/____/____ Single Married Widowed Separated Divorced SS#: _____
(Circle One) (Circle One)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address: _____ Occupation: _____

Employer: _____

Employer Address: _____ City: _____ State: _____ Zip: _____

Family Member Information

Please list the names of your spouse and children.	Is person a patient?		Sex		Age	Date of birth
	Yes	No	M	F		

Please list the names of your spouse and children.	Is person a patient?		Sex		Age	Date of birth
	Yes	No	M	F		

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

INSURANCE INFORMATION

Policy Holders Name: _____ Relationship to Patient: _____ SS#: _____ DOB ____/____/____

Name of Employer: _____ Employer Address: _____ State: _____

Insurance Co. _____ Group #: _____ Address: _____

Secondary Insurance Information

Policy Holders Name: _____ Relationship to Patient: _____ SS#: _____ DOB ____/____/____

Name of Employer: _____ Employer Address: _____ State: _____

Insurance Co. _____ Group #: _____ Address: _____

I certify that all the information (including medical, personal, and insurance records) is true and complete. I give my full permission to Dental Care Kids to check and verify my credit and/or employment history. I further understand that Dental Care Kids will assist me in filing my child's claims, but the insurance coverage I have for dental services can vary and will depend on my insurance plan.

I understand that I am responsible for all fees and services. Since our doctors often provide continuing education to other doctors, I give my permission to use my child's photos for educational purposes.

I give permission, in my absence, to provide examinations, dental cleanings and necessary x-rays as part of routine care for this patient.

We require 48 hours advance notice if you are unable to keep your appointment. Failure to do so could result in a charge. Finance charges will be assessed on any account that is 60 days or more past due

Parent or Guardian: _____

(please complete both sides)



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Date : _____

Child's Name _____ Nickname: _____

Address _____ City _____ State _____ Zip _____

Age: _____ Birth Date: ____/____/____ Social Security: ____-____-____ Sex: Male/ Female

Child's Dental History		Yes	No
1.	Is this your child's first visit to a dentist? When was the last dental visit? _____	___	___
2.	Has your child had any problem with dental treatment in the past?	___	___
3.	Has your child ever received a local anesthetic (novocaine)?	___	___
4.	Has your child ever had fillings or sealants?	___	___
5.	Does your child snack between meals? What are their preferred snacks? _____	___	___
6.	Does your child drink from a bottle or sippy cup?	___	___
7.	Does your child suck their thumb/finger or use a pacifier?	___	___
8.	How often does your child brush his/her teeth? _____	___	___
9.	How often do they floss? _____ Does a parent help brush and floss?	___	___
10.	Do you have fluoridated water at home?	___	___
11.	Does your child drink at least 2 cups of this water per day?	___	___
12.	Does your child receive fluoride supplements? What kind and how often? _____	___	___
13.	Have there been any injuries to teeth, such as falls, blows, chips, etc.?	___	___
14.	Do you have any concerns about your child's teeth? _____	___	___
15.	Since hereditary is a factor in dental health, how would you rate your own teeth? Excellent Good Fair Poor	___	___

Child's Medical History		Yes	No
1.	Physician's Name _____ Telephone _____		
2.	Is your child under the care of a physician now? Since when and why? _____	___	___
3.	Does your child take any medications, vitamins and herbal supplements? Please list _____	___	___
4.	Is your child allergic to anything? Antibiotics, metals, foods, latex, other? _____ Please list _____	___	___
5.	Did your child ever require hospitalization? _____ When? _____ Why? _____	___	___
6.	Does your child get headaches? _____	___	___
7.	Does your child require antibiotic premedication before dental visits?	___	___
8.	Does your child have, or have they ever had, any of the following:		
	AnemiaYes/No		
	Asthma or hay fever.....Yes/No		
	Behavioral/Learning problems.....Yes/No		
	Cerebral Palsy.....Yes/No		
	Congenital birth defects.....Yes/No		
	Diabetes.....Yes/No		
	Dizziness/Fainting.....Yes/No		
	Eyesight problems.....Yes/No		
	Hearing Loss.....Yes/No		
	Persistent Cough.....Yes/No		
	Sinus trouble.....Yes/No		
	Speech impairments.....Yes/No		
	AIDS/HIV Positive.....Yes/No		
	Cancer.....Yes/No		
	Excessive urination.....Yes/No		
	Heart murmur/MVP.....Yes/No		
	Hepatitis.....Yes/No		
	Kidney infection.....Yes/No		
	Liver problems.....Yes/No		
	Reoccurring infections.....Yes/No		
	Rheumatic fever.....Yes/No		
	Severe or prolonged bleeding.....Yes/No		
	Tuberculosis.....Yes/No		
	Ulcers.....Yes/No		