RICHARD J. HEINOWITZ, D.D.S.
Pediatric and Adolescent Dentistry

1 Tell Us About Your Child

Today's Date: _____

Child's Name _____
LAST FIRST MI

Preferred Name: _____ ☐ Male ☐ Female

Child's Birthdate: ___/___/___ Child's Age: _____

School: _____ Grade: _____

Child's Home #: _____ _____

Child's Home Address If different than parents:

_____
APT / CONDO #

_____
CITY STATE ZIP

2 Who is accompanying the child today?

Name: _____ Relation: _____

Who may we Thank for referring you? _____

Other family members seen by us: _____

_____

Your child's dental history

Previous Dentist _____

Last Visit date _____

Were x-rays taken? Yes No

Has your child had regular checkups? Yes No

Has your child had emotional difficulties with previous dental treatment? Yes No

Please explain _____

Is your child taking Fluoride? Yes No

liquid ☐ tablet ☐ Fluoride only ☐ Vitamin & Fluoride ☐

dosage (if known) 0.25 mg ☐ 0.50 mg ☐ 1.0 mg ☐

How often does your child brush daily? 1x 2x 3x

Does your child floss daily? Yes No

Do you assist with brushing? Yes No

Do you assist with flossing? Yes No

What are your primary concerns about your child's teeth? _____

4 Does your child have / had any of the following habits?

Y N	Thumb / Finger Sucking	Y N	Lip Sucking / Biting
Y N	Nursing Bottle Habits	Y N	Pacifier
Y N	Nail Biting	Y N	Grinding or Clenching Teeth

5 Has your child ever had any of the following medical issues?

Y N	Heart Murmur	Y N	Congenital Heart Defect
Y N	Cancer	Y N	Convulsions / Epilepsy
Y N	Diabetes	Y N	Abnormal Bleeding
Y N	Rheumatic Fever	Y N	Hearing Impairment
Y N	HIV + / AIDS	Y N	Any Operations
Y N	Hemophilia	Y N	Any stays in a hospital
Y N	Asthma	Y N	Kidney / Liver Problems
Y N	Hepatitis	Y N	Handicap / Disabilities
Y N	Tuberculosis (TB)	Y N	Allergies to any drugs
Y N	Emotional Disorder	Y N	TMJ Pain - Joint Pain
Y N	Premature Birth	Y N	Lymes

Please indicate if your child's medical history is unknown (i.e. adoption). _____

Please discuss any serious medical problems that the child has had: _____

_____

Please list all drugs that the child is currently taking:

_____

Please list all drugs that the child is allergic to:

_____

Child's Physician and/or Medical Specialist: _____

Phone #: _____ Date of last visit: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No

*** FOR STAFF USE ONLY ***

STAFF REVIEW OF MEDICAL HISTORY_____ DATE_____

STAFF REVIEW OF MEDICAL HISTORY_____ DATE_____

STAFF REVIEW OF MEDICAL HISTORY_____ DATE_____

STAFF REVIEW OF MEDICAL HISTORY_____ DATE_____

6 **Parent or Guardian accompanying minor patient is responsible for payment at the time of service.**

7 **Mother's information: or other's information:** (☐ Step Mother ☐ Guardian)

Name: _____

Address: _____

_____ HM #: _____

CELL #: _____ WK #: _____ Ext: ____

FAX #: _____ EMAIL : _____

Employer: _____

SS #: _____ /DOB: _____

Father's information: or other's information: (☐ Step Father ☐ Guardian)

Name: _____

Address: _____

_____ HM #: _____

CELL #: _____ WK #: _____ Ext: _____

FAX #: _____ E-MAIL: _____

Employer: _____

SS #: _____ /DOB: _____

Parent's Marital Status: ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

8 **Dental Insurance**

Do you have Dental Insurance? Yes___ No___

Do you have orthodontic coverage? Yes___ No___

Balance after insurance is parent or guardian's responsibility._____ initials

*If you are enrolled in one of our **Participating Plans,** listed below, please complete the following information.*

Ameritas
Delta Dental Premier Plan
Delta Dental Preferred
GEHA
Horizon Dental Option
Horizon Traditional
Metlife
United Concordia

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

Policy #_____ Group # _____

Relationship to Patient: _____

Insured's Birthdate: _____

Insured's SS #: _____

Insured's Employer: _____

For all other insurance plans, our office will be very happy to provide you with the information and necessary forms to submit to your carrier for your reimbursement.

9 I understand that the information that I have given is correct to the best of my knowledge, and that it is my responsibility to inform this office of any changes in my child's medical history.

I authorize the dental staff to perform all procedures that have been previously explained and approved.

X _____

Signature of parent or guardian Date

Please fill out this area - ***only*** if you anticipate that your child will be treated ***without*** the presence of a parent or guardian.

I authorize the staff to provide the following preventive and diagnostic procedures, in my absence.

___ Routine checkups and cleanings
___ Diagnostic x-rays

I authorize the staff to provide the following treatment procedures that were previously explained, in my absence

___ Restorative treatment (fillings)
___ Surgical procedures (extractions)

X _____

Signature of parent or guardian Date

10 **MANDATED BY FEDERAL HIPAA LAW ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

You May Refuse to Sign This Acknowledgement

I have received a copy of this office's Notice of Privacy Practices.

Please Print Name _____

Signature **X** _____

Date _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but, Acknowledgement could not be obtained because:

___ *Individual refused to sign*

___ *Communications barriers prohibited obtaining the acknowledgement*

___ *An emergency situation prevented us from obtaining acknowledgement*

___ *Other (Please Specify)*_____

WE APPRECIATE YOUR EFFORTS IN FULLY COMPLETING THIS REGISTRATION FORM.

IT ASSISTS OUR OFFICE IN PROVIDING YOUR CHILD THE *BEST* QUALITY CARE POSSIBLE.

R. HEINOWITZ D.D.S AND STAFF