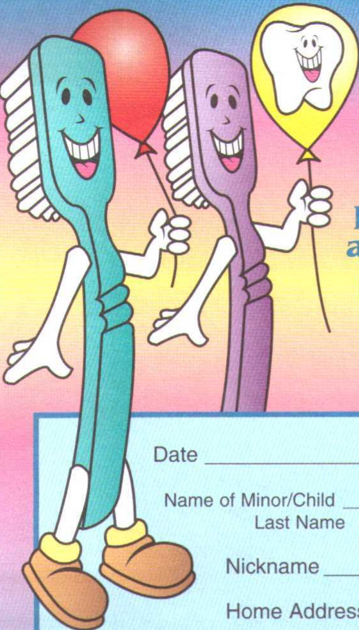
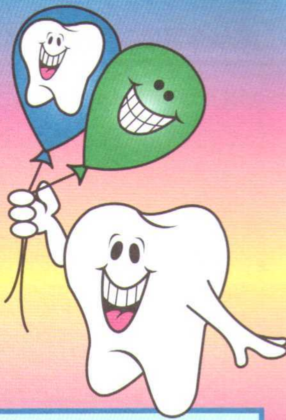


Welcome!



We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date ______________ SS/HIC/Patient ID # ______________ Birthdate ______________

Name of Minor/Child ______________________________ Sex ☐ M ☐ F Age ______________
Last Name First Name Middle Initial

Nickname ______________ Hobbies ______________ Cell Phone (____) ______________

Home Address ______________________________
Street City State Zip

Mailing Address ______________________________
Street City State Zip

School Name ______________________________ School Phone (____) ______________

Person financially responsible ______________ wwPhone (____) ______________ Work Phone (____) ______________

Whom may we thank for referring you? ______________________________

INSURANCE

Father's/Guardian's Name ______________________________

Address (if different from patient's) ______________________________

____

Home Phone (____) ______________ (if different from above) Work Phone (____) ______________ (if different from above)

E-mail ______________________________

Employer ______________________________

Soc. Sec. # ______________ Birthdate ______________

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name ______________ Phone (____) ______________

Address ______________________________

Group # ______________ Policy # ______________

Mother's/Guardian's Name ______________________________

Address (if different from patient's) ______________________________

____

Home Phone (____) ______________ (if different from above) Work Phone (____) ______________ (if different from above)

E-mail ______________________________

Employer ______________________________

Soc. Sec. # ______________ Birthdate ______________

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

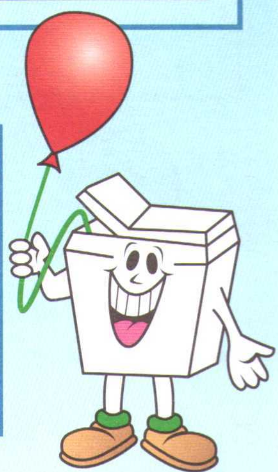
Plan Name ______________ Phone (____) ______________

Address ______________________________

Group # ______________ Policy # ______________

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance I.D. # ______________

DENTAL HISTORY



Date of last visit to a dentist ______________ For what service? ______________

	YES	NO
Has child complained about dental problems?	☐	☐
Does child brush teeth daily?	☐	☐
Does child use floss every day?	☐	☐
Is fluoride taken in any form?	☐	☐
Any injuries to mouth, teeth, head?	☐	☐
Any unhappy dental experiences?	☐	☐
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?	☐	☐

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MEDICAL HISTORY

Minor/Child's Physician ______________________ City/State ______________ Phone (____) __________

Date of last physical examination ______________________ Results ______________________

	YES	NO	
Is Minor/Child under care of physician now?	☐	☐	Medications ______________________
Receiving any medication or drugs?	☐	☐	______________________
Ever been hospitalized?	☐	☐	______________________
Ever had surgery?	☐	☐	Allergies ______________________
Is there excessive bleeding when cut?	☐	☐	______________________

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✔).

☐ A.I.D.S./H.I.V.	☐ Cerebral Palsy	☐ Epilepsy	☐ Kidney Disease	☐ Rheumatic Fever
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Liver Disease	☐ Sinus Problems
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Measles	☐ Thyroid Disease
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Mononucleosis	☐ Tuberculosis
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Hepatitis	☐ Mumps	☐ Other

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?

Name ______________________ Relationship ______________ Phone (____) __________

Name ______________________ Relationship ______________ Phone (____) __________

AUTHORIZATIONS

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of ______________________
Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

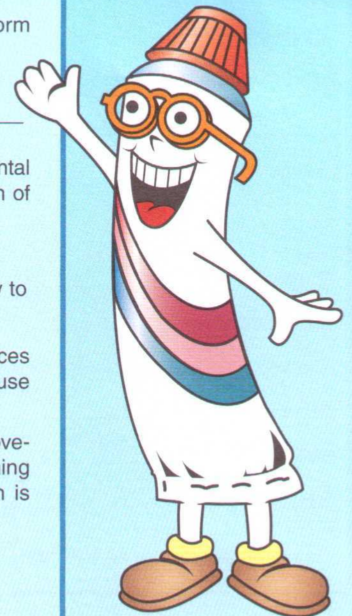
I certify that my dependent(s) is covered by insurance with ______________________ and assign directly to
Name of Insurance Company(ies)

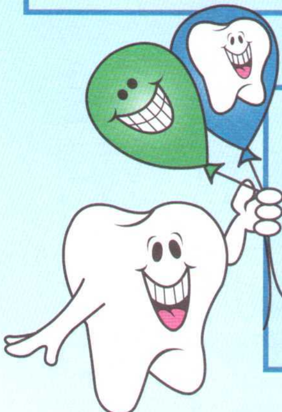
Dr. ______________________ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is

Signature of Parent, Guardian or Personal Representative — Date

Please print name of Parent, Guardian or Personal Representative — Relationship to Patient





UPDATE

TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? ☐ Yes ☐ No

If yes, please describe ______________________

Is patient taking any new medications? ☐ Yes ☐ No If yes, please list ______________________

Date ______________ Parent/Guardian Signature ______________________

Date ______________ Dentist Signature ______________________

Children First Dental Associates, P.C.
Gregory J. Gagliardi, D.M.D.

Patient Information Form

~ ***Patient Name:*** ____________________________

~ *Why did you bring you child in today?* ***(Please Circle)***
- ***First Dental Check-up***
- ***Check up***
- ***Emergency (Please Describe)*** ____________________________________

~ *Has your child ever fallen and bumped his or her face or mouth?* __________
If yes when? _________________________________

~ *When was your child's last dental visit?* ___________________________________

~ *How would you describe your child's behavior at their last dental appointment?*

(Please Circle) ***Excellent*** ***Good*** ***Fair*** ***Poor*** ***Terrible***

~ *Does most of the water used for drinking and cooking come from?*

(Please Circle) ***City Water*** ***Well Water*** ***Bottled Water*** ***Filtered Water***

~ *Is your water fluoridated?*
(Please Circle) ***Yes*** ***No***

~ *Does your child currently take a fluoride supplement?* __________________________
If yes what is the name and dosage of the supplement*?* ___________________

~ *How many times a day are your child's teeth brushed?*

(Please Circle) ***Less than 1*** ***1*** ***2*** ***3*** ***4 or more***

~ *Who brushes your child's teeth?*

(Please Circle) ***Only my child*** ***Only the parent*** ***Both the parent and the child***

~ *How often are your child's teeth flossed****?***

(Please Circle) ***Never*** ***Occasionally*** ***Once a week*** ***Once a day***

~ *At what age did your child stop using the bottle****?*** _____________________________

~ *Was your child ever put to bedtime or naptime with a bottle****?***

(Please Circle) ***Yes*** ***No***

~ *If yes, what types of fluids were in the bottle****?***

(Please Circle) ***Formula*** ***Milk*** ***Juices*** ***Kool Aid \ Fruit Punch*** ***Other___***
~ *Please describe any other pertinent information that we should know about your child so that he/she can be best treated here.* ____
____

______________________________ ______________
Parent Signature ***Date***

Children First Dental Associates, P.C.

Failed Appointment Policy

1. Children First Dental is committed to maintaining wellness and treating oral conditions which could degrade your child's/children's oral health. Early prevention is key to keeping your child disease free.

2. A failed appointment is defined as missing an appointment or canceling an appointment with less than 24 hours notice, or arriving more than 15 minutes late for a scheduled appointment.

3. Failure to show for appointments results in delayed treatment for individuals extends waiting time for routine appointments for other patients and wastes valuable professional services. If you must cancel your appointment at least 24 hours notice must be given to allow scheduling other patients in your time slot.

4. Failure to show for routine check up appointment will result in you being assessed a $50.00 fee; failure to show for an operative appointment will result in you being assessed $100.00 fee. If you fail to show for a second appointment without proper notice you receive a letter dismissing you from our practice.

5. If you have any questions or would like to discuss this failed appointment policy, please contact the office manager. We look forward to providing outstanding dental care to your child.

Gregory J. Gagliardi, D.M.D.

I have read and understand the Children First Dental Associates
Failed Appointment Policy.

____________________________ ______________

Parent Signature Date