Jodi Guttenberg DDS & Associates

WELCOME! PLEASE TELL US ABOUT YOUR CHILD….

CHILD'S NAME first_____middle_____last_____ **GENDER M F**

NICKNAME/PREFERS TO BE CALLED _____ **BIRTHDATE** _____/_____/_____

ADDRESS street_____city_____state_____zip_____

PHONE ( ) _____ **ALTERNATE1( )** _____ **ALTERNATE2( )** _____

FAMILY'S PRIMARY EMAIL ADDRESS _____@_____

FUTURE APPOINTMENTS MAY BE CONFIRMED VIA E-MAIL. PLEASE INFORM THE STAFF IF YOU DO NOT WISH TO RECEIVE THESE E-MAILS.

WHOM MAY WE THANK FOR YOUR REFERRAL? *INTERNET SEARCH _____ *INSURANCE _____ *YELLOW PAGES_____

***ADVERTISEMENT** _____ ***RELATIVE/FRIEND** _____

***PEDIATRICIAN**_____ ***DENTIST**_____ ***OTHER**_____

PARENT/GUARDIAN INFORMATION

PARENT NAME (MOM/DAD)_____ **PARENT NAME (MOM/DAD)**_____

DATE OF BIRTH _____ **DATE OF BIRTH** _____

SSN _____---_____---_____ **SSN** _____---_____---_____

OCCUPATION_____ **OCCUPATION**_____

ADDRESS (IF DIFFERENT FROM ABOVE) _____

DENTAL INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE PLAN NAME _____ **INSURANCE PHONE #** _____
SUBSCRIBER'S NAME _____ **RELATIONSHIP TO PATIENT** _____
SUBSCRIBER'S SSN OR MEMBER/POLICY ID # _____ **MEMBER DOB** _____
GROUP # _____ **SUBSCRIBER'S EMPLOYER** _____

PRIMARY DENTAL INSURANCE PLAN NAME _____ **INSURANCE PHONE #** _____
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DENTAL HISTORY

IS THIS YOUR CHILD'S FIRST VISIT TO A DENTIST? Y / N IF NO, FORMER DENTIST _____
DATE OF LAST DENTAL VISIT _____ REASON? _____
HOW MANY TIMES A DAY IS YOUR CHILD BRUSHING? zero 1x 2x 3x+ DOES HE/SHE FLOSS? Y / N
TAKE FLUORIDE IN ANY OF THESE FORMS: TABLETS/DROPS TOOTHPASTE RINSE/GEL BOTTLED H2O OTHER
HAVE ANY CURRENT COMPLAINT OF DENTAL PAIN? Y/N IF YES, EXPLAIN: _____

DOES YOUR CHILD HAVE A HISTORY OF:
___ THUMB/FINGER SUCKING ___ PACIFIER ___ BOTTLE FEEDING ___ BREASTFEEDING ___ SIPPY CUP
___ SPEECH ISSUES ___ BLEEDING/SORE GUMS ___ MOUTH BREATHING ___ BAD BREATH
___ GRINDING/CLENCHING ____ ABSCESS/INFECTION ____ NAIL BITING ____OTHER _____

MEDICAL HISTORY

PEDIATRICIAN _____ PHONE_____
ADDRESS/TOWN _____ DATE OF LAST PHYSICAL _____
PLEASE LIST MEDICATIONS YOUR CHILD IS CURRENTLY TAKING:

HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY Y / N IF YES, PLEASE EXPLAIN:

DOES YOUR CHILD HAVE ANY ALLERGIES TO ___PENICILLIN/AMOXICILLIN ___SULFA ___ LATEX ___ OTHER
(PLEASE SPECIFYALL KNOWN ALLERGIES INCLUDING FOODS AND ENVIRONMENTAL ALLERGENS):

HAS YOUR CHILD HAD ANY OF THE FOLLOWING? PLEASE CHECK ALL THAT APPLY:

_ AIDS/HIV	_ CEREBRAL PALSY	_ JAUNDICE (SEVERE)	_ SEIZURES
_ ADHD/ADD	_ CONVULSIONS/EPILEPSY	_ KIDNEY DISEASE	_ SINUS PROBLEMS
_ ANEMIA	_ DIABETES	_ LEARNING DISABILITY	_ SPEECH DELAY
_ ASTHMA	_ EAR INFECTIONS (CHRONIC)	_ LIVER DISEASE	_ STOMACH/GI
_ AUTISM/PDD/SPECTRUM	_ GENETIC DISORDER	_ MEASLES	PROBLEMS
_ BIRTH DEFECT	_ HEAD INURY	_ MONONUCLEOSIS	_ TUBERCULOSIS
_ BLEEDING DISORDER	_ HEARING DISABILITY	_ MUMPS	_ TUMOR
_ BLOOD TRANSFUSION	_ HEART MURMUR	_ PSYCHIATRIC CARE	_ VISION PROBLEMS
_ BONE DISORDER	_ HEART PROBLEMS	_ RADIATION THERAPY	_ OTHER (explain below)
_ BRONCHITIS	_ HEPATITIS	_ RESPIRATORY ISSUES	_____
_ CANCER	_ HIGH BLOOD PRESSURE	_ RHEUMATIC FEVER	_____

TO THE BEST OF MY KNOWLEDGE, ALL OF THE PRECEDING ANSWERS AND INFORMATION ARE TRUE AND CORRECT. IF THERE ARE ANY CHANGES IN MY CHILD'S INFORMATION AND/OR HEALTH STATUS, I WILL INFORM THE DOCTOR AS SOON AS REASONABLY POSSIBLE AND WITHOUT FAIL. I UNDERSTAND THAT THIS INFORMATION WILL REMAIN CONFIDENTIAL

SIGNATURE OF PARENT/GUARDIAN _____DATE_____

SIGNATURE OF DOCTOR _____DATE _____

PARENTAL CONSENT

I hereby authorize Dr Jodi Guttenberg, Kidds on Park and/or their Associates any services deemed necessary in the treatment of my child

_____ after consent by parent or guardian.

SIGNATURE OF PARENT/GUARDIAN _____DATE_____

The policy in our office is the parent who accompanies the child is responsible for all fees for services rendered.