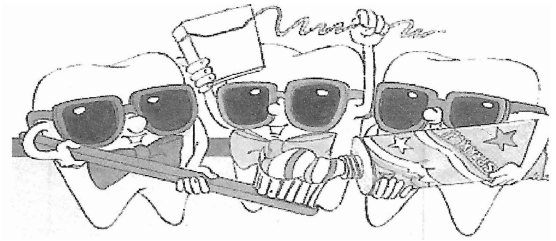


# WELCOME TO OUR PRACTICE!



Please take a few minutes to answer the following questions so we can better care for your child's dental needs.

Tell Us About Your Child	
Web Form Revised Jan 08	Today's Date _____
Child's Name _____ Last First M.I.	
Child's Birthdate ____/____/____	<input type="checkbox"/> Male <input type="checkbox"/> Female
Nickname _____	Social Security No. _____
School _____	Grade _____
Child's Home Telephone No. _____	
Child's Home Address _____	
City _____	State _____ Zip _____
Is the minor/child eligible for treatment under Social Services? If Yes, please check box below. <input type="checkbox"/> Yes <input type="checkbox"/> No	
<input type="checkbox"/> Fidelis	<input type="checkbox"/> Health Plex
<input type="checkbox"/> Medicaid	<input type="checkbox"/> Child Health Plus

General Information
Who is accompanying the child today?
Name _____ Relation _____
Do you have legal custody of this child? <input type="checkbox"/> Yes <input type="checkbox"/> No
Who may we thank for referring you? _____
Other Siblings _____
Child's Previous Dentist _____ Last Visit _____
Name of closest relative not living with you.
Name _____
Address _____
City _____ State _____ Zip _____
Telephone No. _____

Parent's Information	
Parent's marital status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Partnered <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	
<input type="checkbox"/> Father <input type="checkbox"/> Stepfather <input type="checkbox"/> Guardian	<input type="checkbox"/> Mother <input type="checkbox"/> Stepmother <input type="checkbox"/> Guardian
Name _____ Birthdate ____/____/____	Name _____ Birthdate ____/____/____
SS No. _____ Driver's License No. _____	SS No. _____ Driver's License No. _____
Home Telephone No. _____	Home Telephone No. _____
Cell/Other No. _____	Cell/Other No. _____
Employer _____	Employer _____
Employer's address _____	Employer's address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Employer's Telephone No. _____	Employer's Telephone No. _____
If you have dental insurance for the minor/child please complete below.	
Insurance Company _____	Insurance Company _____
Address _____	Address _____
City _____ State _____ Zip _____	City _____ State _____ Zip _____
Insurance Telephone No. _____	Insurance Telephone No. _____
Group No. _____ Policy No. _____	Group No. _____ Policy No. _____

Payment is due at time of service unless prior arrangements have been approved. If this office accepts insurance, I understand that I am responsible for payment at time of services for any co-payment and/or deductible my insurance does not cover. I understand that Robert J. LaCarrubba DDS. requires 2 days (48 hours) notice when cancelling or rescheduling an appointment. I further understand that three (3) late notice cancellations or no shows of any appointments may result in dismissal from the practice. Please insure that you have read and understand these policies.

**ASSIGNMENT AND RELEASE:** I certify that I, and/or my dependent(s), have dental insurance coverage with \_\_\_\_\_ (Insurance Company) and assign directly to Robert J. LaCarrubba DDS, the owner and his associates, all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier(s). I authorize the use of my signature on all insurance submissions.

Robert J. LaCarrubba DDS may use my child's health care information and may disclose such information to the above insurance carrier(s) 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 completed or when cancelled in writing by patient's parent or guardian.

Signature of Parent, Guardian or Personal Representative \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Please print name of Parent, Guardian or Personal Representative \_\_\_\_\_

### Dental Information

Why did you bring the child to the dentist today? \_\_\_\_\_

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Has the child taken any diet pills such as Phen-Fen?  Yes  No  
(also known as Redux or Pondimin.) If so, when? \_\_\_\_\_

Is the child in pain?  Yes  No

Does the child require antibiotics before dental treatment?  Yes  No

Has the child ever had a serious/difficult problem associated with previous dental work?  Yes  No

Is the child's water fluoridated?  Yes  No

Is the child taking fluoridated supplements?  Yes  No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)?  Yes  No

Does the child brush his/her teeth daily?  Yes  No

Floss his/her teeth daily?  Yes  No

Child's Physician \_\_\_\_\_

Telephone No. \_\_\_\_\_ Date of last visit \_\_\_\_/\_\_\_\_/\_\_\_\_

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

Please describe the current physical health.  Good  Fair  Poor

Please list all prescription/over the counter or herbal supplement drugs that the child is currently taking. \_\_\_\_\_

### Medical History

Has the child experienced the following medical problems?

<input type="checkbox"/> Y <input type="checkbox"/> N Abnormal Bleeding	<input type="checkbox"/> Y <input type="checkbox"/> N Hearing Impairment
<input type="checkbox"/> Y <input type="checkbox"/> N ADD/AHD	<input type="checkbox"/> Y <input type="checkbox"/> N Heart Murmur
<input type="checkbox"/> Y <input type="checkbox"/> N AIDs/HIV+	<input type="checkbox"/> Y <input type="checkbox"/> N Hepatitis
<input type="checkbox"/> Y <input type="checkbox"/> N Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N High Blood Pressure
<input type="checkbox"/> Y <input type="checkbox"/> N Any Hospital Stays	<input type="checkbox"/> Y <input type="checkbox"/> N Hives
<input type="checkbox"/> Y <input type="checkbox"/> N Artificial	<input type="checkbox"/> Y <input type="checkbox"/> N Kidney Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N Liver Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Chicken Pox	<input type="checkbox"/> Y <input type="checkbox"/> N Low Blood Pressure
<input type="checkbox"/> Y <input type="checkbox"/> N Congenital Heart Defect	<input type="checkbox"/> Y <input type="checkbox"/> N Lupus
<input type="checkbox"/> Y <input type="checkbox"/> N Convulsions	<input type="checkbox"/> Y <input type="checkbox"/> N Measles
<input type="checkbox"/> Y <input type="checkbox"/> N Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N Mitral Valve Prolapse
<input type="checkbox"/> Y <input type="checkbox"/> N Epilepsy	<input type="checkbox"/> Y <input type="checkbox"/> N Mononucleosis
<input type="checkbox"/> Y <input type="checkbox"/> N Exposed to HIV but Negative	<input type="checkbox"/> Y <input type="checkbox"/> N Prosthetics
<input type="checkbox"/> Y <input type="checkbox"/> N Handicaps/Disabilities	<input type="checkbox"/> Y <input type="checkbox"/> N Rheumatic Fever
	<input type="checkbox"/> Y <input type="checkbox"/> N Scarlet Fever
	<input type="checkbox"/> Y <input type="checkbox"/> N Skin Rash
	<input type="checkbox"/> Y <input type="checkbox"/> N Tuberculosis (TB)

Are the child's immunizations current?  Yes  No

Anything you would like to discuss with the doctor in private?  Yes  No

Please discuss any serious medical problems the child has had. \_\_\_\_\_

### Allergies

Aspirin <input type="checkbox"/> Yes <input type="checkbox"/> No	Metals/Nickel <input type="checkbox"/> Yes <input type="checkbox"/> No
Penicillin/Amoxicillin <input type="checkbox"/> Yes <input type="checkbox"/> No	Latex <input type="checkbox"/> Yes <input type="checkbox"/> No
Codeine <input type="checkbox"/> Yes <input type="checkbox"/> No	Local Anesthetics <input type="checkbox"/> Yes <input type="checkbox"/> No
Tetracycline <input type="checkbox"/> Yes <input type="checkbox"/> No	Acrylic <input type="checkbox"/> Yes <input type="checkbox"/> No

Please list any other drugs/materials your child is allergic to \_\_\_\_\_

Has the child experienced any of the following?

<input type="checkbox"/> Y <input type="checkbox"/> N Breast Fed	<input type="checkbox"/> Y <input type="checkbox"/> N Nursing Bottle Habit
<input type="checkbox"/> Y <input type="checkbox"/> N Chewing on objects	<input type="checkbox"/> Y <input type="checkbox"/> N Speech Problems
<input type="checkbox"/> Y <input type="checkbox"/> N Grinding-Clenching	<input type="checkbox"/> Y <input type="checkbox"/> N Thumb Sucking
<input type="checkbox"/> Y <input type="checkbox"/> N Lip Sucking/Biting	<input type="checkbox"/> Y <input type="checkbox"/> N Tongue/Cheek Biting
<input type="checkbox"/> Y <input type="checkbox"/> N Mouth Breather	<input type="checkbox"/> Y <input type="checkbox"/> N Tongue Thrust
<input type="checkbox"/> Y <input type="checkbox"/> N Nail Biting	<input type="checkbox"/> Y <input type="checkbox"/> N Used Pacifier

**EMERGENCY NOTIFICATION:** In the event of an emergency whom should we contact?

Name _____	Relationship _____	Telephone No. _____
Name _____	Relationship _____	Telephone No. _____

**Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA**

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

I affirm the information that I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's health or medical status.

Signature of Parent, Guardian or Personal Representative \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Please print name of Parent, Guardian or Personal Representative \_\_\_\_\_