87 Elderd Lane
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Preminger Pediatric Dentistry & Orthodontics PLLC
Dental specialists for children, adolescents, & special needs
(516)-239-1200
www.PremingerPediatricDentistry.com

Joel M. Preminger, D.M.D. | Pediatric Dentist
Evan R. Cohen, D.M.D. M.S.D.| Orthodontist
Jason L. Joseph, D.M.D. | Dental Anesthesiologist

Tell Us About Your Child

Today's Date: _____ Child's Home Phone#: (_____) _____ Social Security #: _____

Child's Name: _____ Child's Birthdate: _____ / _____ / _____ Child's Age: _____
Last First MI

Nickname/Preferred Name: _____ ☐ Male ☐ Female Current School: _____ Grade: _____

Child's Home Address: _____
Street City State Zip

Who may we thank for referring you/ How did you find us? (please circle one): ***Facebook*** ***Google/Internet Search*** ***Instagram*** ***Print Ad*** ***Friend/Coworker*** ***Family***

If someone referred you please list their name: _____

Dental History:

Is your child currently in pain? ☐ Yes ☐ No

Is this your childs first dental visit? ☐ Yes ☐ No

Has your child experienced problems with previous dental work? ☐ Yes ☐ No If so, explain: _____

Previous Dentist: _____ Date of Last Visit: _____

Have there been any injuries to your child's teeth jaws, falls, blows, chips, etc. ☐ Yes ☐ No

Has your child been seen by an orthodontist? ☐ Yes, Who? _____ ☐ No

Name of Parent's Dentist: _____ City: _____ Phone: (_____) _____

Does / did your child have any of the following habits? (please circle)

Y N Nail Biting	Y N chewing on objects	Y N TMJ / TMD pain	Y N clenching / grinding teeth
Y N Thumb/ finger sucking	Y N nursing bottle habits	Y N tongue / cheek biting	Y N used pacifier
Y N Tongue Thrust	Y N mouth breather	Y N speech problems	Y N breast fed

Medical History:

Child's Physician: _____ Phone: (_____) _____ Date of last visit: _____

Address: _____

Is your child currently under the care of a physician? ☐ Yes ☐ No Please explain: _____

Does your child have social/personality/temperament concerns that we should be aware of? _____

Please describe your child's current physical health: ☐ Good ☐ Fair ☐ Poor **Are Immunizations Current?** ☐ Yes ☐ No

Please list all medications and dosage that your child is currently taking: _____

Please list all drugs and / or things that cause your child allergic reactions: _____

Anything you would like to discuss with the Doctor in Private? ☐ Yes ☐ No

Has your child had / experienced any of the following: (please circle)

Y N Abnormal Bleeding	Y N Diabetes	Y N Low Blood Pressure
Y N AIDS / HIV +	Y N Endocrine System Disorders	Y N Lupus
Y N Allergies	Y N Epilepsy	Y N Measles
Y N Anemia	Y N Frequent Infections	Y N Mitral Valve Prolapse
Y N Any Hospital Stays	Y N Handicaps	Y N Mononucleosis
Y N Any Operations	Y N Behavior / Learning / Disabilities	Y N Recurrent Headaches / Frequency
Y N Asthma	Y N Mentally / Physically Disabled	Y N Rheumatic Fever
Y N Autism	Y N Hearing Impaired	Y N Seizures
Y N Blood Dyscrasis	Y N Heart Murmur	Y N Scarlet Fever
Y N Blood Transfusion/Date	Y N Hemophilia	Y N Sickle Cell Anemia
Y N Breathing / Lung Problems	Y N Hepatitis	Y N Sight Disorders
Y N Cancer / Tumors	Y N High Blood Pressure	Y N Significant Injuries/ What
Y N Chicken Pox	Y N Hives	Y N Skin Rash
Y N Congenital Birth Defect	Y N Kidney Problems	Y N Tonsilitis
Y N Congenital Heart Defect	Y N Liver / GI System Problems	Y N Tuberculosis (TB)

Please discuss any serious medical problems your child experiences, now or in the past: _____

_____

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Parent's Information:

Father/ Step:

Marital Status: ☐ Married ☐ Single ☐ Divorced

DOB: ____ /____ / ____ Cellphone #: _____ Work Phone #: _____

Name: _____ Social Security#: _____ Email: _____

Address (if different from above): _____
City State Zip

Employer: _____ Occupation: _____ Length of Employment: _____

Employer Address: _____
City State Zip

Mother/ Step:

DOB: ____ /____ / ____ Cellphone #: _____ Work Phone #: _____

Name: _____ Social Security#: _____ Email: _____

Address(if different from above): _____
City State Zip

Employer: _____ Occupation: _____ Length of Employment: _____

Employer Address: _____
Street City State Zip

Name of parent(s) who resides with the child: _____

Nearest relative: _____ Address: _____ Phone: _____

Is your child covered by a dental insurance plan? ☐ Yes ☐ No

Dental Insurance Information:

Insurance Co. Name: _____ Policy #: _____ Group # (Plan, Local, or Policy#): _____

Insurance Co. Address: _____
PO Box Street City State

Relationship to Patient: _____

Insured Employer: _____

Who is the primary on the insurance (whom is the insurance under)?: _____

Financial Responsibility

I assume financial responsibility for all dental treatment and medications provided for my child, and understand that payment is expected on the date services are provided. I request and authorize my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I therefore am ultimately responsible for payment of services rendered on my behalf or my dependents.

Signature _____ Date _____

Authorization and Release

To the best of my knowledge the information I have given on this form is correct, and I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the period of such dental care to third party payors and / or their health practitioners.

I have received a copy of this office's Notice of Privacy Practices. I consent to their use and disclosure of my children(s) Protected Health Information to carry out treatment, payment activities and healthcare operations.

Signature _____ Date _____