

Patient's Registration and History

Welcome to our Practice! To provide the best and safest comprehensive dental care for your child we are thanking you in advance for completing our detailed medical history form.

Please print in black or blue ink.

Mary E. Tierney DDS, MS Rebecca J. Testa DDS, MS Allison McMahon DDS Esther Levine Pincus DMD Diplomates, American Board of Pediatric Dentistry

Child's Name:		Preferred Name:		
Birthdate:	Age:Gende	r: Male Female		
Street Address:				
City:	State:	Zip Code:		
Home Phone:		-		
Diagon shook VEC (V) on N(2 (N) as it applies to your shild	•		
Y N	O (N) as it applies to your child Y N	Y N MRSA		
□ □ ADD/ADHD	□ □ Brain Injury	□ □ Epilepsy/Seizures □ □ MSPI		
	□ □ Bruises Easily			
	•			
□ AIDS/HIV	Cerebral Palsy Chamical Panandanae			
☐ Allergy to Augmentin				
☐ Allergy to Latex		☐ Heart Disease/Condition ☐ Sickle Cell Disease		
□ Allergy to Peanuts		☐ ☐ Heart Murmur ☐ ☐ Sickle Cell Trait		
□ Allergy to Omnicef/Ceph	☐ Child Abuse	☐ Innocent Heart ☐ ☐ Speech Impairment		
☐ Allergy to Pen/Amox	☐ ☐ Cleft Palate/Lip	□ Needs SBE/Antibiotic □ □ Thyroid Disease		
 Allergy to Sulfa meds 	□ □ Cold/Canker Sores	☐ ☐ Hemophilia ☐ ☐ Tonsillitis		
 Allergies - seasonal 	□ Depression	☐ ☐ Hepatitis ☐ ☐ Tuberculosis		
Anemia	 Developmental Delay 	☐ ☐ High Blood Pressure ☐ ☐ Tumor, Cancer		
 Asthma/Reactive Airway 	☐ Motor	□ □ Injury - front teeth □ □ Wheelchair		
 Autism / Aspergers 		□ Juvenile Rheumatoid Arthritis □ □ Other:		
 Behavioral Problems 	Cognitive	□ Kidney Disease		
□ Birth Defect	□ □ Diabetes	□ Liver Disease		
□ Blood Transfusion	 Down Syndrome 	☐ ☐ Lung Disease		
□ Bone / Joint Problems	 Earaches/Ear infections 	□ Metal Implant/Pins/Rods		
Child's Medical Doctor:	Pho	ne: Date of last exam:		
Is your child presently und	er the care of a physician or sp	pecialist for any reason?		
☐ YES ☐ NO Explain:				
	Phone:			
,				
Is your child taking any me	dications? Supplements? Or V	/itamins?		
, , ,	••			
120 2110 2101				
Does your child have any a	llergies to medicines, latex, fo	ods, or metals not listed above?		
Are antibiotics necessary	prior to dental work because o	of a heart murmur, defect, prosthesis, shunt, or any other		
medical reason(s)?	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ransaman, acreet, procure, criain, or any care.		
` ,				
Has your child been hospit	alized, sedated, or had surgery	/?		
		, ·		
Hae any mambay of the fam	aily including your abild bad.	nrohlom with godation or report angether:		
-		a problem with sedation or general anesthesia?		
YES NO Explain:		□ No		
Are your child's immunizat	ions up to date?	□ No		
Is there any other health in	formation that should be know	/n?		
•				

Dental History

Is this your child's first dental visit? Previous Dentist:	☐ YES ☐ NO Date of Last Exam:	Date	of Last X-F	Rays:		
How often does your child brush?		Is tooth brushing supervised? ☐ YES ☐ NO Is dental floss used? ☐ YES ☐ NO				
	wing (check all that apply Fluoridated tap water Fluoride tablets/drops mg			□ Vitamins □ che □ gui		
Please indicate if your child has any of Currently Breastfeeding Bottle Feeding Cheek Biting Teeth Grinding/clinching	the following mouth habi Thumb or finger suckir Pacifier Nail biting Sippy Cup		all that ap	oply): ☐ Gagging ea ☐ Mouth bream ☐ Snoring		
Please estimate your child's daily expose Water: cups	ks: cups Cand iter: cups Fruit	y: bouches: snacks:: fruits:		ups snack? ups	our child's f	avorite
Has your child suffered any injuries to y YES NO Explain:						
Has your child had recent dental pain o		m that nee	eds specia	al attention?		
Does your child wear a mouth guard fo	r sports?	□ YES	□ NO			
Is there anyone in the family with a hist	ory or missing teeth?	□ YES	□NO	Extra teeth:	□ YES	□ NO
Do you have any questions prior to you	ır child's visit today?	□ YES	□NO			
	Consent					
The permission of the above patient, I audigital x-rays) for my child by Dr. Tierney, Dr. proposed treatment plan, I authorize Dr. Tierney medically necessary or advisable (local and necessary, and advisable for the comfort and whistory. I have also reported any prior allergic of agree to inform Dr. Tierney, Dr.Testa, Dr. McM. Signature:	Or.Testa, Dr. McMahon, Dr. Levey, Dr. Testa, Dr. McMahon, Desthetic and/or nitrous oxide) and vell-being of my child. I have given unusual reactions to medical lahon, Dr. Levine Pincus and the is valid until revoked	mance of room rine Pincus a r. Levine Pincus ong with part ven an accur tions, latex, their staff of a in writing.	utine dental and their stances and the tient manag rate report foods, or me any change	services and diagonal services and diagonal services and be designed as a service and any other in the medical hards.	signated. If y anesthetics that are rehaded and hysical and her disease history. This	I accept a cs considered easonable, I mental health or condition. I authorization
Because referrals are im	portant to us, who may v Dentist/Orthodontist/Dod Friend: Google Yelp Facebook	tor:			ffice?	

Please take note that as of January 1st 2011, City Kids Dental implemented a cancellation policy. If you fail to show to the appointment or cancel with less than 48 hours notice, there will be a charge for each appointment missed or cancelled.