# CENTRAL PARK WEST PEDIATRIC DENTISTRY

327 Central Park West, New York, NY 10025
(212) 280-1700

Today's Date ______________________

Patient's Name ____________________ Birth Date ____________ Age __________

Male ❒ Female ❒

Patient's Address ____________________ City, State, Zip ____________________

Names and Ages of Siblings (if applicable) ____________________

Hobbies, Pets, Nickname ____________________ School ____________________

Parent's Name ____________________ Birth Date ____________________

Address ____________________ Social Sec # ____________________

City, State, Zip Code ____________________ Home # ____________________

Email Address ____________________ Cell # ____________________

Occupation ____________ Company ____________ Business # ____________

Parent's Name ____________________ Birth Date ____________________

Address ____________________ Social Sec # ____________________

City, State, Zip Code ____________________ Home # ____________________

Email Address ____________________ Cell # ____________________

Occupation ____________ Company ____________ Business # ____________

Marital Status of Parents ____________________

Family Sitter ____________________ Phone # ____________________

What Is Your Preferred Method of Contact? ❒ Home Phone ❒ Cell Phone ❒ Work Phone ❒ Email

Whom May We Thank For Referring You? ❒ Internet ❒ Pediatrician ____________________

❒ Friend ____________________ ❒ Other ____________________

<u>Payment Information</u>

Name on Card ____________________ Card No. ____________________

Exp Date ____________ CVV Code ____________

Dental Insurance Co ____________________ Primary Plan Holder ____________________

Member ID # ____________________ Group #: ____________________

Claim Mailing Address ____________________

Insurance Phone # ____________________

<u>PLEASE NOTE:</u> CENTRAL PARK WEST PEDIATRIC DENTISTRY DOES NOT PARTICIPATE WITH DENTAL INSURANCE PLANS.
AS A COURTESY, WE WILL SUBMIT ALL CLAIMS TO YOUR INSURANCE ON YOUR BEHALF FOR REIMBURSEMENT.

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## DENTAL HISTORY

Is this your child's first trip to the dentist? ❐ Yes ❐ No

If not, please provide the date of last visit and the dentist's name ______________________________

Please tell us why you're here ❐ Routine Visit ❐ Emergency ❐ Other ___________________________

Has your child ever been treated for dental injury, toothache, or other emergencies? ________________

______________________________________________________________________

How has your child behaved during previous dental visits (if applicable)? __________________________

## MEDICAL HISTORY

Pediatrician/ Physician _________________________ Phone Number______________________

Please state any medical, emotional, or behavioral condition that your child has or is suspected of having. Please be specific ______________________________________________________________

Does your child take any medication? If so, please state medication and dosage, if known _____________

______________________________________________________________________

Does your child have any allergies to medication? If so, please state ___________________________

Does your child have any LATEX allergies? If so, please state ________________________________

Does your child have any food or seasonal allergies? If so, please state _________________________

Have you even been told that your child has a heart murmur? ________________ If yes, do they require antibiotic premedication before a dental visit? ______________________

Preferred Pharmacy: _____________________ Phone Number: ___________________

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PLEASE CHECK ANY CONDITION THAT APPLIES

| | | | | | |
|---|---|---|---|---|---|
| Bleeding Disorders | ❐ | Neurological Disorders | ❐ | Kidney Disease | ❐ |
| Heart Disease | ❐ | Urinary Tract Disorders | ❐ | Sickle Cell Disease | ❐ |
| Gastro Intestinal Disease | ❐ | History of Surgery | ❐ | Learning Disorders | ❐ |
| Asthma | ❐ | Diabetes | ❐ | Possibility of Pregnancy | ❐ |
| AIDS | ❐ | Arthritis | ❐ | Blood Transfusions | ❐ |
| Seizures | ❐ | Liver Disorders | ❐ | Premature Birth | ❐ |

Other: ________________________________________________________________

______________________________________________________________________

Signature of Parent/Guardian ____________________ Relationship ___________ Date __________

The parent/guardian whose signature appears above is responsible for all fees when services are rendered and consents to treatment as explained to them by the dentist or dental professional.