Patient Name:_______________________________________ Nickname:_________________________________

Date of Birth: ___________________________________ Age: __________ Sex: ☐ Male ☐ Female

Address: ____ City : _____________________ Zip: _________

School: ____ Grade: ________________________

Previous Dentist & Address: ____

Pediatrician & Address: ____

Whom may we thank for referring you to us? ____

Names of siblings: ____

Father's Name ______________________________

☐ Single ☐ Separated ☐ Married ☐ Divorced

Address (If different than child) ____________________

____

Home Phone ( ) ____________ - ____________

Cell Phone ( ) _____________ - _____________

Work Phone ( ) _____________ - ____________

Employer ___________________________________

Soc. Sec. #__________ - _______ - _______________

Birth Date __________________________________

Email _______________________________________

Do you have dental insurance coverage for your child? ☐ Yes ☐ No

Ins. Co. Name ________________________________

Group # _____________________________________

ID # ____

Mother's Name ________________________________

☐ Single ☐ Separated ☐ Married ☐ Divorced

Address (If different than child) ________________________

____

Home Phone ( ) _____________ - _______________

Cell Phone ( ) ______________ - ________________

Work Phone ( ) _____________ - _______________

Employer ______________________________________

Soc. Sec. #__________ - _________ - ______________

Birth Date ______________________________________

Email ____

Do you have dental insurance coverage for your child? ☐ Yes ☐ No

Ins. Co. Name ___________________________________

Group # ____

ID # ____

Patients Name: ____

Has your child grown very much in the past year? Yes ______ No _______

Female Patients: Monthly periods? Yes ___ No ___ Started age: ______ Possibility of being pregnant? ________

Male Patients: Voice Changes? Yes ________ No _________ Facial Hair? Yes __________ No __________

General Health: excellent __________ fair __________ poor __________

Presently under care for: ____

Birth Defects: ____

Drugs & Medications being taken now (name & dose): _____________________________________

____

Allergic to what medications: ____

Is your child having any problems with the following: (please circle all that apply)

Cavities Toothache Teeth Sensitive Trauma Gum Infections/Swelling Sensitivity Crowdedness Color

****** Please circle any of the following which your child has had or may have at the present time ******

Adenoids Removed
AIDS (HIV Positive)
Allergy to Medications
Anemia
Angina Pectoris
Arthritis
Artificial Heart Valve
Artificial Joint
Asthma
Autism
Blood Disorder
Blood Transfusion
Bone Disorder
Breathing Difficulties
Cancer
Cold Sores
Congenial Heart Disease
Convulsions
Damaged Heart Valve
Diabetes
Dizziness

Drug Addiction
Endocrine Disorder
Epilepsy
Epistaxis (nosebleeds)
Fainting Spells
Genital Herpes
Glaucoma
Hay Fever
Heart Disease or Attack
Heart Failure
Heart Murmur
Heart Pacemaker
Heart Surgery
Hepatitis
High Blood Pressure
Hospitalized
Hyperactivity
Injuries
Jaundice
Kidney Disorder
Liver Disorder

Leukemia
Lung Disorder
Mitral Valve Prolapse
Neurosis
Pain in Jaw Joint
Psychiatric Treatment
Rheumatic Fever
Rheumatism
Scoliosis
Seizures
Sinus Trouble
Tonsils Removed
Tuberculosis (TB)
Thyroid Disease
Ulcers
Venereal Disease
X-Ray Treatment (not diagnostic)

Other

NONE OF THE ABOVE

Please elaborate on any items checked: ____

____

____

____

Patient Name:_______________________________________ Nickname:________________________________

Date of Birth: ___________________________________ Age: __________ Sex: ▯ Male ▯ Female

Address: ____ City : _____________________ Zip: _________

School: ____ Grade: ________________________

Previous Dentist & Address: ____

Pediatrician & Address: ____

Whom may we thank for referring you to us? ____

Names of siblings: ____

Father's Name ________________________________

▯ Single ▯ Separated ▯ Married ▯ Divorced

Address (If different than child) ____________________

____

Home Phone ( ) ____________ - ____________

Cell Phone ( ) ____________ - ____________

Work Phone ( ) ____________ - ____________

Employer ___________________________________

Soc. Sec. #__________ - _______ - ______________

Birth Date __________________________________

Email ______________________________________

Do you have dental insurance coverage for your child? ▯ Yes ▯ No

Ins. Co. Name _______________________________

Group # ____________________________________

ID # _______________________________________

Mother's Name __________________________________

▯ Single ▯ Separated ▯ Married ▯ Divorced

Address (If different than child) ________________________

____

Home Phone ( ) _____________ - _______________

Cell Phone ( ) ______________ - ________________

Work Phone ( ) _____________ - _______________

Employer ______________________________________

Soc. Sec. #__________ - _________ - _______________

Birth Date _____________________________________

Email ____

Do you have dental insurance coverage for your child? ▯ Yes ▯ No

Ins. Co. Name __________________________________

Group # _______________________________________

ID # ____

Patients Name: ____

Has your child grown very much in the past year? Yes ______ No _______

Female Patients: Monthly periods? Yes ___ No ___ Started age: ______ Possibility of being pregnant? ________

Male Patients: Voice Changes? Yes ________ No _________ Facial Hair? Yes __________ No __________

General Health: excellent __________ fair __________ poor __________

Presently under care for: ____

Birth Defects: ____

Drugs & Medications being taken now (name & dose): ____

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Is your child having any problems with the following: (please circle all that apply)

Cavities Toothache Teeth Sensitive Trauma Gum Infections/Swelling Sensitivity Crowdedness Color

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Artificial Joint
Asthma
Autism
Blood Disorder
Blood Transfusion
Bone Disorder
Breathing Difficulties
Cancer
Cold Sores
Congenial Heart Disease
Convulsions
Damaged Heart Valve
Diabetes
Dizziness

Drug Addiction
Endocrine Disorder
Epilepsy
Epistaxis (nosebleeds)
Fainting Spells
Genital Herpes
Glaucoma
Hay Fever
Heart Disease or Attack
Heart Failure
Heart Murmur
Heart Pacemaker
Heart Surgery
Hepatitis
High Blood Pressure
Hospitalized
Hyperactivity
Injuries
Jaundice
Kidney Disorder
Liver Disorder

Leukemia
Lung Disorder
Mitral Valve Prolapse
Neurosis
Pain in Jaw Joint
Psychiatric Treatment
Rheumatic Fever
Rheumatism
Scoliosis
Seizures
Sinus Trouble
Tonsils Removed
Tuberculosis (TB)
Thyroid Disease
Ulcers
Venereal Disease
X-Ray Treatment (not diagnostic)

Other

NONE OF THE ABOVE

Please elaborate on any items checked: ____

____

____

____

Consent

Dear Parent or legal guardian,

Since my children_______________________________________ are minors, it becomes necessary that a signed permission is obtained from a parent or legal guardian before any dental services can be started and accomplished by either Dr. Dawn-Marie Felicetti or any dental staff associated with Shore Smiles 4 Kids.

Authorization is hereby granted to do an examination, take x-rays, clean teeth, give fluoride treatment, apply sealants if needed and provide oral hygiene instructions if deemed necessary. Following a consultation, authorization is hereby granted to administer any treatment, anesthetics, extractions, and perform such operations or otherwise treat my child as it may be deemed necessary and or advisable. I also give permission to provide my child with emergency care if needed.

I authorize my pediatrician or other physician(s)/medical facilities to release any and all pertinent medical information regarding my children.

I further understand that this consent will remain in effect until such time that I choose to terminate it.

I understand that I accept responsibility for payment of services rendered.

I certify the truth of the information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit references.

Signed:____ Date:__________________

Parent or legal guardian

NOTICE OF PRIVACY ACKNOWLEDGEMENT

Shore Smiles 4 Kids

I understand that under the Health Insurance Portability & Accountability Act of 1996("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to :

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third party payers.
- Conduct normal healthcare operation such as quality assessments and physician certifications.

I have received, read and understand your Notice Of Privacy Practices containing a more complete description of uses and disclosures of my health information. I understand that this organization has the right to change its Notice Of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice Of Private Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

______________________________	______________________________
Childrens' Names	Relationship to Patient
______________________________	______________________________
Signature	Date

Record Request Form

I , ____, *hereby request*
Parent or legal guardian name

that ALL dental records for ____
Name of children

From ____
Previous Dentist Name or Practice Name

Be emailed or forwarded to:

Shore Smiles 4 Kids
Dr. Dawn-Marie Felicetti
1035 Park Blvd., Suite 2D
Massapequa Park, New York 11762
(516) 795-5939
SHORESMILES4KIDS@GMAIL.COM

Thank you for your anticipated cooperation.

____ *Date:* ____________________
Signature of parent or legal guardian