PATIENT INFORMATION

Patient Name:	Nickname:			
Date of Birth:	Age:	Sex:	2 Male	② 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	Mother's Name			
2 Single 2 Separated 2 Married 2 Divorced	☑ Single ☑ Separated	₃ Ma	rried	2 Divorced
Address (If different than child)	Address (If different than child			
Home Phone ()	Home Phone ()			
Cell Phone ()	Cell Phone ()		-	
Work Phone ()	Work Phone()			
Employer	Employer			
Soc. Sec. #	Soc. Sec. #			
Birth Date	Birth Date			
Email	Email			
Do you have dental insurance coverage for your child? 2 Yes 2 No	Do you have dental insurance	coverage	for your chi	ld? ② Yes ② No
Ins. Co. Name	Ins. Co. Name			
Group #	Group #			
ID#	ID#			

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): Is your child having any problems with the following: (please circle all that apply) Cavities Toothache Teeth Sensitive Trauma Gum Infections/Swelling Sensitivity Crowdedness *** Please circle any of the following which your child has had or may have at the present tine Adenoids Removed Drug Addiction Leukemia AIDS (HIV Positive) Endocrine Disorder Lung Disorder Allergy to Medications Epilepsy Mitral Valve Prolapse Anemia Epistaxis (nosebleeds) Neurosis Angina Pectoris Fainting Spells Pain in Jaw Joint Arthritis Genital Herpes Psychiatric Treatment Artificial Joint Hay Fever Rheumatism Selida Heart Valve Glaucoma Rheumatic Fever Artificial Joint Hay Fever Rheumatism Heart Disease or Attack Scoliosis Autism Heart Disease or Attack Scoliosis Removed Blood Disorder Heart Murmur Sinus Trouble Tonsis Removed Blood Transfusion Heart Pacemaker Tonsis Removed Bone Disorder Heart Surgery Tuberculosis (TB) Breathing Difficulties Heart Surger			
General Health: excellent fair poor Presently under care for: Birth Defects: Drugs & Medications being taken now (name & dose): Is your child having any problems with the following: (please circle all that apply) Cavities Toothache Teeth Sensitive Trauma Gum Infections/Swelling Sensitivity Crowdedness *** Please circle any of the following which your child has had or may have at the present tine Adenoids Removed Drug Addiction Leukemia Lung Disorder Allos (HIV Positive) Endocrine Disorder Lung Disorder Allergy to Medications Epilepsy Mitral Valve Prolapse Anemia Epistaxis (nosebleeds) Neurosis Anemia Epistaxis (nosebleeds) Neurosis Pain in Jaw Joint Arthritis Genttal Herpes Psychiatric Treatment Artificial Heart Valve Glaucoma Rheumatism Asthma Heart Disease or Attack Scoliosis Autism Heart Pailure Seizures Blood Disorder Heart Murmur Sinus Trouble Blood Transfusion Heart Pacemaker Tonsils Removed Bone Disorder Heart Surgery Tuberculosis (TB) Herathing Difficulties Hepatitis Thyroid Disease Congenial Heart Disease Hyperactivity X-Ray Treatment (not displace) Dizziness Liver Disorder NONE OF THE A			
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Birth Defects:			
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 **** Please circle any of the following which your child has had or may have at the present tine			
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Please elaborate on any items checked:			

Patients Name: _____

PATIENT INFORMATION

Patient Name:	Nickname:			
Date of Birth:	Age:	Sex:	2 Male	② 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	Mother's Name			
2 Single 2 Separated 2 Married 2 Divorced	2 Single 2 Separated	2 Marrie	d	2 Divorced
Address (If different than child)	Address (If different than child)		
Home Phone ()	Home Phone ()			
Cell Phone ()	Cell Phone ()			
Work Phone ()	Work Phone()			
Employer	Employer			
Soc. Sec. #	Soc. Sec. #			
Birth Date	Birth Date			
Email	Email			
Do you have dental insurance coverage for your child? 2 Yes 2 No	Do you have dental insurance	coverage for	your chil	d? ② Yes ② No
Ins. Co. Name	Ins. Co. Name			
Group #	Group #			
ID#	ID#			

Has your child grown v	ery much in the pas	t year? Y	'es No				
Female Patients: Mon	thly periods? Yes	No _	Started age:	Possibili	ty of being pro	egnant?	
Male Patients: Voice C	Changes? Yes	No	Fa	acial Hair? Ye	s	_ No	
General Health: excell	ent f	air	poor				
Presently under care fo							
Birth Defects:							
Drugs & Medications b	eing taken now (na	me & dose)):				
Allergic to what medic	ations:						
	ls your child having	any proble	ems with the follow	ing: (please ci	rcle all that ap	oply)	
Cavities Toothache	Teeth Sensitive	Trauma	Gum Infections/Sv	welling Sens	sitivity Crov	vdedness Color	
*** Please ci	rcle any of the fol	lowing wh	nich your child has	had or may	have at the p	oresent time ***	
Adenoids Removed		Drug	Addiction		Leukemia		
AIDS (HIV Positive)		Endo	ocrine Disorder		Lung Disorder		
Allergy to Medications Epilepsy Mitral Valve Prolapse		e Prolapse					
Anemia		•	axis (nosebleeds)		Neurosis		
Angina Pectoris			ting Spells		Pain in Jaw .		
Arthritis			tal Herpes		Psychiatric T		
Artificial Heart Valve			coma		Rheumatic I		
Artificial Joint		•	Fever		Rheumatisn	n	
Asthma			t Disease or Attack		Scoliosis		
Autism			t Failure		Seizures		
Blood Disorder			t Murmur		Sinus Troub		
Blood Transfusion			t Pacemaker		Tonsils Rem		
Bone Disorder			t Surgery		Tuberculosi		
Breathing Difficulties		Hepa			Thyroid Dise Ulcers	case	
Cancer Cold Sores		_	Blood Pressure pitalized		Venereal Di	2222	
Congenial Heart Diseas	S Q	-	eractivity			sease ment (not diagnostic)	
Congenial Heart Diseas	DC	nype Injur	•		A-Nay Heat	ment (not diagnostic)	
Damaged Heart Valve		Jaun			Other		
Diabetes			ey Disorder		Other		
Dizziness			Disorder		NONE O	F THE ABOV	
Diagon als branches	المراجعات ومسوطاني						
Please elaborate on an	y items checked:						

Patients Name: _____

PATIENT INFORMATION

Patient Name:	Nickname:		
Date of Birth:	Age:	Sex: ② M	ale 🛭 Female
Address:	City :	z	ip:
School:	Grade:		
Previous Dentist & Address:			
Pediatrician & Address:			
Whom may we thank for referring you to us?			
Names of siblings:			
Father's Name	Mother's Name		
2 Single 2 Separated 2 Married 2 Divorced	Single	2 Married	2 Divorced
Address (If different than child)	Address (If different than child)	
Home Phone ()	Home Phone ()		
Cell Phone ()	Cell Phone ()		
Work Phone ()	Work Phone()		
Employer	Employer		
Soc. Sec. #	Soc. Sec. #		
Birth Date	Birth Date		
Email	Email		
Do you have dental insurance coverage for your child? 2 Yes 2 No		,	
Ins. Co. Name	Ins. Co. Name		
Group #	Group #		
ID#	ID#		

Has your child grown very m	nuch in the past	t year? Y	'es No _				
Female Patients: Monthly p	eriods? Yes	No _	Started age: _	Pos	sibility of be	ing pregnant?	
Male Patients: Voice Chang	es? Yes	No		Facial Hair?	Yes	No	
General Health: excellent _	fa	air	poor				
Presently under care for:							
Birth Defects:							
Drugs & Medications being t	taken now (nar	ne & dose)):				
Allergic to what medications	S:						
<u>Is you</u>	ır child having	any proble	ems with the follow	wing: (plea	se circle all t	that apply)	
Cavities Toothache Tee	eth Sensitive	Trauma	Gum Infections/S	Swelling	Sensitivity	Crowdedness	Color
*** Please circle o	any of the foll	<u>owing wh</u>	ich your child ha	s had or n	nay have a	t the present til	me ***
Adenoids Removed		Drug	Addiction		Leuke	emia	
AIDS (HIV Positive) Endocrine Disorder			Lung Disorder				
Allergy to Medications Epilepsy Mitral Valve Prolapsy		l Valve Prolapse					
Anemia Epistaxis (nosebleeds) Neurosis							
Angina Pectoris			ing Spells		_	n Jaw Joint	
Arthritis			tal Herpes		•	iatric Treatment	
Artificial Heart Valve			coma			matic Fever	
Artificial Joint		•	Fever		Rheui	matism	
Asthma			t Disease or Attack	(Scolic		
Autism			t Failure		Seizui		
Blood Disorder			t Murmur			Trouble	
Blood Transfusion			t Pacemaker			ls Removed	
Bone Disorder			t Surgery			rculosis (TB)	
Breathing Difficulties		Hepa			Thyro Ulcers	id Disease	
Cancer Cold Sores		•	Blood Pressure			s real Disease	
Congenial Heart Disease		•	oitalized eractivity			real bisease Treatment (not d	ingnestic)
Convulsions		Injur	•		∧-ndy	rreatifient (not a	iiagi IUSLIC)
Damaged Heart Valve		Jaun			Other		
Diabetes			ey Disorder		Other		
Dizziness			Disorder		NOI	NE OF THE A	ABOVE
Diago alabarata an any ita-	ne checked.						
Please elaborate on any iten	ns cnecked:						

Patients Name: _____

Consent

Dear Parent or legal guardian,	
Since my child	is a minor, it becomes necessary that a signed n before any dental services can be started and accomplished by sociated with Shore Smiles 4 Kids.
Authorization is hereby granted to do an examination fluoride treatment, apply sealants if needed and provice consultation, authorization is hereby granted to admin extractions, and perform such operations or otherwise deemed necessary and or advisable. I also give permise emergency care if needed.	de oral hygiene instructions if deemed necessary. Following a nister any treatment, anesthetics, e treat my child as it may be
I authorize my pediatrician or other physician(s)/med pertinent medical information regarding my child.	ical facilities to release any and all
I further understand that this consent will remain in elementate it.	ffect until such time that I choose to
I understand that I accept responsibility for payment of	of services rendered.
I certify the truth of the information given. I also auth information to those persons requiring it for the treatm of payment of the account or credit references.	
Signed:	
Parent or legal guard	nan

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.

Child or Childrens' Name	Relationship to Patient
Signature	Date

Record Request Form

Ι,		, hereby request
Parent or	J	
that ALL dental records for		
•	Name of child or children	
From		
Pre	evious 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	
The section of the se		
Thank you for your anticipated co	ooperation.	
	Date:	
Signature of parent or le	gal guardian	