PATIENT INFORMATION

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 # _____

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 INFORMATION

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 # _____

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 INFORMATION

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 # _____

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 INFORMATION

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 # _____

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: _____

_____

_____

_____

_____

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, N.Y. 11762
(516) 795-5939
SHORESMILES4KIDS@GMAIL.COM

Thank you for your anticipated cooperation.

_____ *Date:* _____
Signature of parent or legal guardian