

**We are pleased to welcome you and your child to our practice, Toothville Pediatric Dentistry!**
Please take a few minutes to fill out this form as completely as you can.
If you have any questions, we’ll be glad to help you. We look forward to
 working with you in maintain your child’s dental health!

**PATIENT INFORMATION**
NAME OF CHILD:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BIRTHDATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
SEX:M\_\_\_F\_\_\_ AGE:\_\_\_\_\_\_NICKNAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HOBBIES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
HOME/MAILING ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
HOME PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WORK PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_CELLPHONE:\_\_\_\_\_\_\_\_\_\_\_\_
PERSON FINANCIALLY RESPONSIBLE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
EMAIL:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
WHOM WE MAY THANK FOR REFERRING YOU?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**PARENT/GUARDIAN**
NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BIRTHDATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
SEX:M\_\_\_F\_\_\_HOW ARE YOU RELATED TO THIS CHILD?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
HOME/MAILING ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
CITY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_STATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ZIP:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**(ONLY IF THE ADDRESS IS DIFFERENT FROM THE ONE ABOVE)**

**PRIMARY INSURANCE**
NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BIRTHDAY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
SOC.SEC#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HOME/CELL/WORKPHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
EMPLOYER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
INSURANCE NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_INSURANCE PHONE NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
INSURANCE ID/POLICY NYMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GROUP NUMBER:\_\_\_\_\_\_\_\_\_\_\_
 **SECONDARY INSURANCE**NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_BIRTHDATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
SOC.SEC#\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HOME/CELL/WORK PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
EMPLOYER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
INSURANCE NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_INSURANCE PHONE NUMBER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
INSURANCE ID/POLICY NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_GROUP NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL HISTORY**

DATE OF LAST VISIT TO DENTIST:\_\_\_\_\_\_\_\_\_\_\_\_\_\_FOR WHAT SERVICE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
Has child complained about dental problems? YES/NO
Is fluoride taken in any form? YES/NO
Does child brush teeth daily? YES/NO
Any injuries to mouth/teeth/head? YES/NO
Does child floss daily? YES/NO
Any unhappy dental experiences? YES/NO
Any mouth habits(thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?) YES/NO

**MEDICAL HISTORY**
CHILD’S PHYSICIAN/PEDIATRICIAN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
ADDRESS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE NUMBER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
DATE OF LAST EXAMINATION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RESULTS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
IS CHILD UNDER THE CARE OF PHYSICIAN NOW? YES/NO
MEDICATIONS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
RECEIVING ANY MEDICATIONS OR DRUGS? YES/NO
EVER BEEN HOSPITALIZED?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YES/NO
ALLERGIES:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
EVER HAD SURGERY? YES/NO
IS THERE EXCESSIVE BLEEDING WHEN CUT? YES/NO
IF YES, REASON?:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
**HAS CHILD HAD ANY HISTORY OF OR DIFFICULTY WITH ANY OF THE FOLLOWING? PLEASE CIRCLE:**
A.I.D.S/H.I.V YES/NO HEARING PROBLEM YES/NO
ANEMIA YES/NO HEART PROBLEM YES/NO
ASTHMA YES/NO HEPITITIS YES/NO
BLADDER PROBLEMS YES/NO KIDNEY DISEASE YES/NO
CANCER YES/NO LIVER DISEASE YES/NO
CEREBRAL PALSY YES/NO MEASLES YES/NO
CHICKEN POX YES/NO MONONUCLEOSIS YES/NO
CONVULSION YES/NO MUMPS YES/NO
DIABETES YES/NO RHEUMATIC FEVER YES/NO
DRUG/ALCOHOL ABUSE YES/NO SINUS PROBLEMS YES/NO
EPILEPSY YES/NO THYROID DISEASE YES/NO
FAINTING YES/NO TUBERCULOSIS YES/NO
Other health problems? Please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IN AN EVENT OF AN EMERGENCYM WHOM MAY WE CALL?**
NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_PHONE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Dr. Yasemin Kilical
2175 Lemoine Ave Suite# 301
Fort Lee, NJ 07024**

**Payment Terms and Information Release**

To All of Our Valued Patients:

We would like you to understand the following:

* In compliance with the HIPPAA Privacy Rules, your signature on this form represents an authorization and consent for our office to release your medical information to your insurance company and/or to any physician who requests of our examination. I have received a copy of the Health Insurance Portability and Accountability Act(HIPPAA) NOTICE of PRIVACY PRACTICES.
* If your insurance company rejects your claim, you will be responsible for this payment. Please be advised that in case of a delinquent account, there will be a 30% collection fee added to your bill!
* While the doctor feels that there are certain procedures that are medically necessary for your care, these procedures may not be covered by your insurance. Should this happen, payment for these procedures will be your responsibility.

I have read and understand the above, and I agree to these payment terms.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
 Date