smiles 4 kids
MANHATTAN PEDIATRIC DENTAL GROUP, PC

Mark S. Hochberg, DMD
Sean C. Adler, DMD
Keren Etzion, DDS

Welcome!

We would like to welcome you and your child to our office. Our practice is based on preventive care and our goal is to make every child's visit pleasant and educational. We strive to teach good oral care that will enable your child to have a beautiful Smile that lasts a lifetime!

This form can be filled out electronically. If you are unable to fill out this form due to technical reasons, ensure that you are viewing it with Adobe Acrobat Reader. Download Acrobat here.

This form has 2 pages, please fill it out completely.

Date: _____

1. Child's Name: _____ M◯ /F◯ Nickname: _____
2. Date of Birth: _____ Brother(s)/Sister(s) (Ages): _____
3. Child's Address: _____ Phone: _____
4. Your Name: _____ Relation to Child: _____ Email: _____
5. Your Address (if different): _____
6. Husband's/Wife's/Partner's Name: _____
7. Relationship Status: Choose
8. Who is responsible for this account?: _____
9. Address of this person: _____
10. Employed by: _____ Type of Work: _____
11. Business phone, Father: _____ Mother: _____ Cell #: _____
12. Whom may we thank for referring you?: _____
13. Where/whom may we call regarding your appointment?: _____
14. Child's Physician: _____ Phone: _____
15. Parent's Dentist: _____ Phone: _____
16. Social Security #: _____

Please continue to page 2

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Answer only applicable questions by selecting Yes or No.

	Yes	No
Does your child have any health problems?	○	○
Has your child seen a physician in the last year? (other than checkups)	○	○
Has your child ever been hospitalized?	○	○
Does your child take medicines regularly?	○	○
Is your child taking vitamins with iron?	○	○
Is your child allergic to penicillin or other substances?	○	○
Does your child have an emotional or nervous problem?	○	○
Does your child have any dental problems now?	○	○
Has your child ever been to a dentist before?	○	○
Was the visit a good experience?	○	○
Has your child seen a dentist in the last six (6) months?	○	○
Has your child ever had dental x-rays?	○	○
Has your child's experience with other doctors been pleasant?	○	○
Has your child ever had a toothache?	○	○
Have your child's teeth ever been injured in an accident?	○	○
Does your child have any oral habits? (pacifier, thumb, finger, nail biting)	○	○
Do you help brush your child's teeth?	○	○
Does your child have a bottle with milk or juice?	○	○
Does your child fall asleep with a milk or juice bottle?	○	○
Do you nurse your child to sleep?	○	○

Has your child ever had a history of:

Heart murmur:	○ Yes	○ No	Asthma:	○ Yes	○ No	Bleeding disorder:	○ Yes	○ No
Anemia:	○ Yes	○ No	Kidney/Liver disorder:	○ Yes	○ No	Rheumatic fever:	○ Yes	○ No
Epilepsy/convulsions:	○ Yes	○ No	Speech problems:	○ Yes	○ No	Tuberculosis:	○ Yes	○ No
Heart trouble:	○ Yes	○ No	Diabetes:	○ Yes	○ No	Any unusual conditions:	○ Yes	○ No

Additional Comments:

To the best of my knowledge, all of the preceding answers are true and correct. If my child ever has a change in his/her health or medicines, I will inform the doctor(s). I hereby authorize treatment by the doctor(s) in caring for my child.

Signature: Dated:

Print Form Submit Form

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Practice Limited to Dentistry for Children, Young Adults & Special Needs