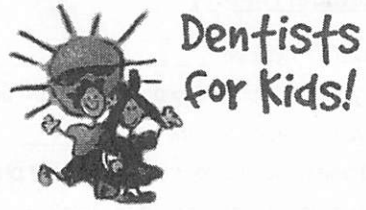
Welcome to South Shore Pediatric Dentistry and Orthodontics!

ROSS E. GRUBER, DDS | | DAVID ZARABI, DDS
285 SILLS RD., STE 3B | EAST PATCHOGUE, NY 11772
TEL: (631) 289-9000 | FAX: (631) 289-9009



Thank you for choosing us to be your child's dental care provider.
Please take a few minutes to fill out this form.
We look forward to working with you and your child!

Patient's Information and Health History

Child's Full Name _____ Nickname _____

Date of Birth ____/____/____ Age _____ Sex: *M F* Grade _____ Patient lives with: ☐ Mother ☐ Father ☐ Both ☐ Other

Name(s) and age(s) of other children in family _____

Name(s) of other children seen in this office _____

Whom may we thank or referring you to our office? _____

Is this your child's first visit? *Yes No* If no, name of former dentist _____

Who is your family dentist? _____

Parents' Marital Status (circle one) *Single Married Separated Divorced Widowed*

Guarantor (Person responsible for payment of dental services)

Guarantor _____

Relationship *Mother Father Guardian Stepmother Stepfather*

Date of Birth _____ SS # _____

Address _____

City _____ State _____ Zip _____

Primary (Daytime) Phone _____

Secondary (Cell) Phone _____

Email _____

Drivers License # _____ State _____

Secondary Contact

Name _____

Relationship *Mother Father Guardian Stepmother Stepfather*

Date of Birth _____ SS # _____

Address _____

City _____ State _____ Zip _____

Primary (Daytime) Phone _____

Secondary (Cell) Phone _____

Email _____

Drivers License # _____ State _____

Insurance Information - Please give all your insurance cards to the receptionist. *If no insurance, check here: ___ Self Pay*

Primary Insurance _____ Relationship to Patient _____

Employer _____ Group # _____ Member ID _____

Secondary Insurance _____ Relationship to Patient _____

Employer _____ Group # _____ Member ID _____

Pharmacy Information

Name _____ Phone _____

Address _____

Medical History

Child's Physician _____ Phone _____

Is your child currently under the care of a physician? *Yes* *No*

If yes, please explain: _____

Please describe your child's current physical health. *Good* *Fair* *Poor*

Are all immunizations up-to-date? *Yes* *No*

Does your child have any allergies to latex/medications (penicillin/Novocain, etc) /food/other? *Yes* *No*

If yes, please list: _____

Has your child been diagnosed with or treated for any of the following:

Y N *AIDS/HIV*	Y N *Cleft Palate/Lip*	Y N *Hepatitis Type ___*
Y N *Anemia*	Y N *Diabetes*	Y N *High / Low Blood Pressure*
Y N *Any Hospital Stays/Surgeries*	Y N *Epilepsy/Seizures*	Y N *Kidney Problems*
Y N *Asthma*	Y N *Hearing/Speech Issues*	Y N *Learning Disabilities*
Y N *ADHD*	Y N *Heart Disease*	Y N *Liver Problems*
Y N *Autism*	Y N *Heart Murmur*	Y N *Sinus Problems/Sleep Apnea*
Y N *Cerebral Palsy*	Y N *Hemophilia Type ___*	Y N *Tuberculosis (TB)*

If yes to any of the above or other not listed, please explain _____

_____

Please list all medications your child is taking _____

Dental History

What is the **primary** reason for your visit today? _____

Does your child currently have problems with any of the following?

Y N *Cavities*	Y N *Tongue habit*	Y N *Tooth Alignment*	Y N *Color of Teeth*
Y N *Gum Infection*	Y N *Oral habits*	Y N *Speech*	Y N *Sensitive Teeth*
Y N *Toothache*	Y N *Bites fingernails*	Y N *Trauma*	Y N *Other _____*

Has your child experienced problems with previous dental work? *Y* *N*

Please explain _____

Does your child take a fluoride multivitamin? *Y* *N* If yes, what kind? _____

Does your child brush his/her teeth daily with fluoride toothpaste? *Y* *N*

Does your child floss his/her teeth daily? *Y* *N*

Was your child bottle/breast-fed? *Y* *N* Age stopped? _____

Does your child have oral habits? *Y* *N* If yes, describe _____

Does your have speech, occupational, or physical therapy? *Y* *N*

Does your child play any sports? *Y* *N* If yes, what sports? _____

Previous Dentist _____ Date of last visit _____

Why did you leave your last dentist? _____

Authorization and Release

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize Dr. Gruber, Dr. Tran, and Dr. Zarabi to perform necessary dental procedures including, but not limited to, the use of nitrous oxide, local anesthesia and take any necessary radiographs to diagnose and/or treat my child's dental needs. I also authorize Dr. Gruber, Dr. Tran, and Dr. Zarabi to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payer and/or other healthcare practitioners.

Signature of Patient (or Parent/Guardian if minor) _____ Relationship _____

Please Print Name _____ Date _____