CENTRAL PARK WEST PEDIATRIC DENTISTRY

327 Central Park West, New York, NY 10025
(212) 280-1700

Today's Date _____

Patient's Name _____ Birth Date _____ Age _____

Male ❒ Female ❒

Patient's Address _____ City, State, Zip _____

Names and Ages of Siblings _____

Hobbies, Pets, Nickname _____ School _____

Parent's Name _____ Birth Date _____

Address _____ Social Sec # _____

City, State, Zip Code _____ Home # _____

Email Address _____ Cell # _____

Occupation _____ Company _____ Business # _____

Parent's Name _____ Birth Date _____

Address _____ Social Sec # _____

City, State, Zip Code _____ Home # _____

Email Address _____ Cell # _____

Occupation _____ Company _____ Business # _____

Marital Status of Parents _____

Family Sitter _____ Phone # _____

What Is Your Preferred Method of Contact? ❒ Phone _____ ❒ Email _____

Whom May We Thank For Referring You? ❒ Internet _____ ❒ Pediatrician _____

❒ Friend _____ ❒ Other _____

Payment Information

Credit Card Name _____ No. _____ Exp Date _____

Dental Insurance _____ Primary Plan Holder _____

Group # _____ ID # _____

Claim Mailing Address _____

Insurance Phone # _____

NOTE: CENTRAL PARK WEST PEDIATRIC DENTISTRY DOES NOT PARTICIPATE WITH DENTAL INSURANCE PLANS. AS A COURTESY, WE WILL SUBMIT ALL CLAIMS TO YOUR INSURANCE ON YOUR BEHALF FOR REIMBURSEMENT.

DENTAL HISTORY

Is this your child's first trip to the dentist? ❒ Yes ❒ No
If not, please provide the date of last visit and the dentist's name _____

Please tell us why you're here ❒ Routine Visit ❒ Emergency ❒ Other _____

Has your child ever been treated for dental injury, toothache, or other emergencies? _____

_____

How has your child behaved during previous dental visits (if applicable)? _____

MEDICAL HISTORY

Pediatrician/ Physician _____ Phone Number_____

Please state any medical, emotional, or behavioral condition that your child has or is suspected of having. Please be specific _____

Does your child take any medication? If so, please state medication and dosage, if known _____

_____

Does your child have any allergies to medication? If so, please state _____

Does your child have any LATEX allergies? If so, please state _____

Does your child have any food or seasonal allergies? If so, please state _____

Have you even been told that your child has a heart murmur? _____ If yes, do they require antibiotic premedication before a dental visit? _____

PLEASE CHECK ANY CONDITION

Bleeding Disorders	❒	Neurological Disorders	❒	Kidney Disease	❒
Heart Disease	❒	Urinary Tract Disorders	❒	Sickle Cell Disease	❒
Gastro Intestinal Disease	❒	History of Surgery	❒	Learning Disorders	❒
Asthma	❒	Diabetes	❒	Possibility of Pregnancy	❒
AIDS	❒	Arthritis	❒	Blood Transfusions	❒
Seizures	❒	Liver Disorders	❒	Premature Birth	❒

Other _____

_____

Signature of Parent/Guardian _____ Relationship _____ Date _____

The parent/guardian whose signature appears above is responsible for all fees when services are rendered and consents to treatment as explained to them by the dentist or dental professional.