JUSTIN C BERMAN, D.M.D. **PEDIATRIC DENTISTRY**
KRISTINE HONG, D.D.S.

PATIENT INTRODUCTION

Please assist us by answering all of the following questions. This confidential information is important for our records in evaluating and treating your child.

PATIENT INFORMATION DATE _____

Child's Name _____ Nickname _____ M ☐ F ☐

Age _____ Date of Birth _____ School _____

Whom may we thank for referring you? _____

Do you give consent for pictures to be taken and shared via social media? Yes ☐ No ☐

Do you give consent for pictures to be taken and shared for advertisements? Yes ☐ No ☐

FAMILY RECORD

Residence Address _____ City_____ State_____ Zip_____

Residence Phone _____ Cell Phone _____

Parent's full name _____ M ☐ F ☐ Driver's lic.**#** _____ DOB _____

Address (if different) _____ Phone _____

Occupation _____ Employed by _____ SS# _____

Business Address _____ Business Phone _____

Email Address _____ Marital Status _____

Parent's full name _____ M ☐ F ☐ Driver's lic.**#** _____ DOB _____

Address (if different) _____ Phone _____

Occupation _____ Employed by _____ SS# _____

Business Address _____ Business Phone _____

Email Address _____ Marital Status _____

Please list the names of your child's brothers & sisters and their ages _____

Has any member of your family been a patient at this office before? Yes ☐ No ☐

If yes, please name _____

Will anyone else (step-parent, grandparent, etc.) be bringing the child in and speaking with the doctor? Yes ☐ No ☐

DENTAL INSURANCE

Name of insured _____ Relationship to Child _____

DOB _____ SS# _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____

Insurance Company _____ Group # _____ Policy # _____

Insurance Company Address _____

Insurance Company Phone # _____

DO YOU HAVE ADDITIONAL DENTAL INSURANCE? If yes, complete below.

Name of insured _____ Relationship to Child _____

DOB _____ SS# _____

Name of Employer _____ Union or Local # _____ Work Phone _____

Address of Employer _____

Insurance Company _____ Group # _____ Policy # _____

Insurance Company Address _____

Insurance Company Phone # _____

I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered for my dependents.

Financial Responsibility

(If parents do not live together, the parent that accompanies the child will be responsible for payment at each visit.)

SIGNATURE OF PARENT X _____

DENTAL HISTORY

Child's Name _____ Date of last dental visit: _____

Reason for today's visit _____

Former Dentist _____ City/ State _____

Has your child had an unfavorable experience in a previous dental (medical) office? _____

Have there been any injuries to your child's teeth or jaw (falls, blows, chips, etc.)? _____

Does your child receive fluoride vitamins, tablets, water, etc.? _____

Has an orthodontist seen your child? If so, who? _____

Name of family dentist (parent's dentist) _____

CHILD'S HABITS

Does your child:	Suck his/her thumb/finger?	Yes ☐ No ☐
	Suck/bite his/her lips?	Yes ☐ No ☐
	Bite/chew his/her nails or hard objects?	Yes ☐ No ☐
	Grind his/her teeth?	Yes ☐ No ☐
	Clench his/her jaw?	Yes ☐ No ☐

MEDICAL HISTORY

Physician's Name _____ Date of last visit: _____

Phone # _____ Medical Record # (if applicable) _____

Is your child presently under the care of a physician for any medical problem or condition? Yes ☐ No ☐

If so, please describe: _____

Is your child currently taking any medication? Yes ☐ No ☐

Please list names and dosages: _____

Has your child ever been hospitalized or has surgery? Yes ☐ No ☐

Please describe (for what condition and when) _____

Has your child ever had any of the following:

Asthma	Yes ☐ No ☐	Liver Disorder	Yes ☐ No ☐
Cancer	Yes ☐ No ☐	Kidney Disorder	Yes ☐ No ☐
Hepatitis	Yes ☐ No ☐	Gastrointestinal Disorder	Yes ☐ No ☐
Hemophilia/ Blood Disorder	Yes ☐ No ☐	Diabetes	Yes ☐ No ☐
Rheumatic Fever	Yes ☐ No ☐	Congenital Heart Defect	Yes ☐ No ☐
Allergies	Yes ☐ No ☐	Heart Murmur	Yes ☐ No ☐
Epilepsy or Seizures	Yes ☐ No ☐	Anemia	Yes ☐ No ☐
Tuberculosis	Yes ☐ No ☐	Red Dye Allergy	Yes ☐ No ☐
ADD/ADHD	Yes ☐ No ☐	Latex Allergy	Yes ☐ No ☐

Please describe any medical problems your child has: _____

Is your child developmentally delayed, physically handicapped, or have any learning or emotional disabilities? Yes ☐ No ☐

If so, please describe: _____

Please describe any other medical history or problem you feel should be brought to the doctor's attention: _____

_____

Please describe your child's allergies to any medications or foods: _____

_____

I HEREBY AUTHOTIZE DR. JUSTIN BERMAN OR DR. KRISTINE HONG TO PERFORM A DENTAL EXAMINATION INCLUDING DENTAL X-RAYS, IF NECESSARY, FOR MY ABOVE-NAMED CHILD. ANY ADDITIONAL PROCEDURES BEYOND A DENTAL CLEANING WILL BE EXPLAINED TO ME PRIOR TO INITIATION OF SUCH PROCEDURES.

SIGNATURE: _____ RELATIONSHIP TO CHILD: _____ DATE: _____