Mt. Kisco
Pediatric Dentistry

PATIENT & FAMILY RECORD

Tell Us About Your Child

Child's Name: _____

Nickname: _____
Siblings that we treat: _____
_____

Child's birth date: _____/_____/_____
Child's age: _____
Child's home phone number: (____)_____
Child's home address: _____

_____

Who may we thank for referring you to our office?
_____
_____

Mother's Information

Name: _____

Birth date: ___/___/ ____ Marital Status: _____

Employer: _____
Work number: (____)_____ Ext: _____
Home number: (____)_____
Cell number: (____)_____
Email: _____

Father's Information

Name: _____

Birth date: ___/___/____ Marital Status: _____

Employer: _____
Work number: (____)_____
Home number: (____)_____
Cell number: (____)_____
Email: _____

Who is Accompanying the Child Today?

Name: _____
Relationship: _____
Do you have legal custody of this child? YES NO

Person Responsible for Account

Name: _____
Relationship: _____
Billing Address: _____
_____

Home number: (____)_____
Work number: (____)_____
Cellular number: (____)_____
E-mail: _____

Primary Dental Insurance

Insurance Co. Name: _____
Insurance Co. Address: _____
_____

Insurance Co. Phone: (____)_____
Group # (Plan, Local, or Policy #): _____
Policy Owner's Name: _____
Relationship to Child: _____
Policy Owner's birth date: _____/_____/_____
Social Security Number: _____-_____-_____
Policy Owner's Employer: _____

Secondary Dental Insurance

Insurance Co. Name: _____
Insurance Co. Address: _____
_____

Insurance Co. Phone: (____)_____
Group # (Plan, Local, or Policy #): _____
Policy Owner's Name: _____
Relationship to Child: _____
Policy Owner's birth date: _____/_____/_____
Social Security Number: _____-_____-_____
Policy Owner's Employer: _____
Child's Name: _____

Preferred E-mail Address For Statements and Appointment reminders:

_____

105 South Bedford Road, Suite 315, Mt. Kisco, NY 10549
P: 914.339-0180 F: 914.487.7980 www.mtkiscopediatricdentistry.com

Child's Name: _____

Dental History

Is this your child's first visit to the dentist? Y N

If not, how long since the last visit? _____

Were any x-rays taken? _____

Have there been any injuries to the face, teeth, or mouth? _____

If yes, please explain: _____

_____

_____

Why did you bring the child to the dentist today?

_____

_____

Does the child have any of the following habits?

Y N Lip sucking/biting Y N Nail biting

Y N Thumb/finger sucking Y N Nursing/bottle

Has your child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain: _____

_____

_____

Is your child's water fluoridated? Yes No Unsure

Is your child taking fluoride supplements? Yes No

Has your child ever had any pain or tenderness in his/her jaw/joint (TMJ/TMD)? Yes No

Does your child brush his/her teeth daily? Yes No

Floss his/her teeth daily? Yes No

Health History

Has the child ever had any of the following conditions?

Y	N	Abnormal bleeding	Y	N	Handicaps/Disabilities
Y	N	Allergies to any drugs	Y	N	Hearing impairment
Y	N	Any hospital stays	Y	N	Heart Disease/Murmur
Y	N	Any Operations	Y	N	Hemophilia/Bleeding Disorders
Y	N	Asthma	Y	N	Hepatitis
Y	N	Cancer	Y	N	HIV + / AIDS
Y	N	Congenital Birth Defects	Y	N	Kidney/Liver Conditions
Y	N	Convulsions/Epilepsy	Y	N	Rheumatic/Scarlet Fever
Y	N	Pregnancy	Y	N	Allergies to Latex Products
Y	N	Tuberculosis	Y	N	Diabetes

If you answered yes above, please provide details:

_____

_____

_____

Please list all medications child is currently taking:

_____

_____

Please list all medications/foods/substances child is allergic to: _____

_____

_____

Pediatrician's Name: _____

Phone number: (____)_____

Is the child currently under the care of a physician? Y N

INFORMED CONSENT

- I have provided this information to the best of my knowledge and will be held responsible for informing the office of Mt. Kisco Pediatric Dentistry of any changes to my child's health and/or insurance information.
- I authorize Dr. Loan Mao DDS and staff to perform diagnostic procedures and treatment deemed necessary for my child's oral health.
- I authorize my insurance company to pay Dr. Loan Mao, DDS PC all insurance benefits otherwise payable to me for services rendered. I also authorize the use of this signature on all insurance submissions.
- I understand that I am responsible for all charges for services rendered whether or not it is covered by my insurance and that all payments are due on the day services are rendered.
- This consent is to remain in effect until cancelled in writing.

_____

Parent/Guardian Signature Date

- I give permission to Mt. Kisco Pediatric Dentistry to use photos of my child on educational literature, website, brochure, and social media. I may request to have pictures removed at any time.

_____

Parent/Guardian Signature Date