Welcome

Elena Stavisky, DMD, LLC
341 Haddon Avenue
Haddon Township, NJ 08108
(856) 833-1172

Today's Date: _____

Tell Us About Your Child

Child's name: _____
Child's nickname: _____
Male _____ Female _____
Child's Birthday: _____/_____/_____
Child's Age: _____
School: _____
Grade: _____
Child's Home Phone Number (_____) _____
Child's Home Address: _____

Who may we thank for referring you to our office?

_____

Mother's Information

Name: _____
Mother Stepmother Guardian Birthdate: _____/_____/_____
Email Address: _____
Employer: _____
Home # (_____) _____
Cell # (_____) _____
Social Security # _____
Driver's License # _____

Father's Information

Name: _____

Father Stepfather Guardian Birthdate: _____/_____/_____

Email Address: _____

Employer: _____

Home # (_____) _____

Cell # (_____) _____

Social Security # _____

Driver's License # _____

Who Is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? _____

Person Responsible for Account

Name _____

Relationship _____

Billing Address _____

Home # (_____) _____

Cell # (_____) _____

Email address _____

Primary Dental Insurance

Insurance Co Name: _____

Insurance Co Address: _____

Insurance Co # (_____)_____

Group # (Plan or Policy #) _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: _____/_____/_____

Social Security #: _____

Policy Owner's Employer: _____

Secondary Dental Insurance

Insurance Co Name: _____
Insurance Co Address: _____
Insurance Co # (_____)_____
Group # (Plan or Policy #) _____
Policy Owner's Name: _____
Relationship to Patient: _____
Policy Owner's Birthdate: _____/_____/_____
Social Security #: _____
Policy Owner's Employer: _____

Dental History

Is this your child's 1st visit to the dentist? _____
If not, how long since the last visit? _____
Previous Dentist's Name _____
Were any x-rays taken at the previous dental visits? _____
Have there been any injuries to the teeth, face 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 Nursing/Bottle Habits Y N Thumb/Finger Sucking

Has the child ever had any difficult problems associated with previous treatment? _____
If yes, please explain

_____

Health History

Does the child have any of the following conditions?

Y N Abnormal Bleeding
Y N Allergies to any Drugs
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Congenital Birth Defects
Y N Convulsions/Epilepsy
Y N Pregnancy
Y N Tuberculosis
Y N Add/ADHD

Y N Disabilities/Special Needs
Y N Hearing Impairment
Y N Heart Disease/Murmur
Y N Hemophilia/Blood Disorders
Y N Hepatitis
Y N HIV and/or AIDS
Y N Kidney/Liver Conditions
Y N Rheumatic/Scarlet Fever
Y N Allergies to Latex
Y N Diabetes
Y N Autism

Please discuss and serious medical conditions that the child has or had

_____

_____

Please list all current drugs that the child is taking

_____

_____

Please list all allergies

_____

_____

Child's Physician _____

Phone (_____)_____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services that my child may need.

_____ _____ _____

Signature of the Parent of Guardian Date Relationship to Patient

_____