

Jamie Diament-Golub, D.M.D. and Elizabeth Simon D.D.S. & Associates

Child's Name \_\_\_\_\_ M/F Birth Date \_\_\_\_\_  
First MI Last  
Address \_\_\_\_\_ Town \_\_\_\_\_ Zip \_\_\_\_\_ Ph# \_\_\_\_\_

Parent 1 \_\_\_\_\_ Soc Sec # \_\_\_\_\_ Cell # \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
E-mail \_\_\_\_\_ @ \_\_\_\_\_

Parent 2 \_\_\_\_\_ Soc Sec # \_\_\_\_\_ Cell # \_\_\_\_\_  
Occupation \_\_\_\_\_ Employer \_\_\_\_\_ Work Phone \_\_\_\_\_  
E-mail \_\_\_\_\_ @ \_\_\_\_\_

I will be paying for my first visit with : Cash \_\_\_ Check \_\_\_ Credit Card \_\_\_\_\_

Whom may we thank for referring you? \_\_\_\_\_

Names and ages of other children \_\_\_\_\_

Family Dentist \_\_\_\_\_ Child's Physician \_\_\_\_\_ Phone # \_\_\_\_\_

Name of medications taken recently by your child (including vitamins) \_\_\_\_\_

Has your child had any type of allergic reaction to any food, medicine, or other substances? Please describe below

Has your child ever been hospitalized? \_\_\_\_\_ If yes, give details \_\_\_\_\_

Does your child have a heart murmur or heart defect? \_\_\_\_\_ If yes, give details \_\_\_\_\_

If the patient has had any of the following diseases or conditions, please check one(s):

- Measles       Diabetes       Bleeding Problems       AIDS/AIDS related complex
- Chicken Pox       German or "3 day" Measles       Asthma or Wheezing       Skin Problems
- Mumps       Hearing Difficulties       Rheumatic Fever       Bone/Joint Problems
- Scarlet Fever       Speech Difficulties       Kidney Disease       Growth Abnormalities
- Pneumonia       Emotional Difficulties       Tuberculosis       Whooping Cough
- Birth Defects       Fainting or Dizziness       Epilepsy/Seizures       Broken Bones
- Poor Vision       Sickle Cell Anemia       Serious Accidents       Liver Disease/Hepatitis
- Anemia       Removal of Tonsils or Adenoids       Cancer

**\_\_\_ THERE IS NO HISTORY OF THESE PROBLEMS**

Does your child have any of the following? \_\_\_Autism \_\_\_ADD \_\_\_PDD

What is your main reason for bringing your child today? \_\_\_\_\_

Is this the child's first dental visit? \_\_\_ If not, when was the last visit and for what reason? \_\_\_\_\_

Were dental x-ray films ever taken of your child? \_\_\_\_\_ By whom? \_\_\_\_\_

Does your child have any of the following habits?

- Thumb Sucking       Mouth Breathing       Speech Problems       Pacifier
- Using the bottle       Tongue Thrusting       Grinding of the teeth

Has your child ever had any injury to the face or teeth? \_\_\_\_\_

Has your child ever had an unfavorable reaction to local OR general anesthesia? \_\_\_\_\_

I give my consent for general dental treatment by Jamie Diament-Golub, D.M.D. and Dr. Elizabeth Simon D.D.S. & Assoc. Furthermore, the undersigned will be responsible for any fee incurred on the above child for dental treatment rendered.

X \_\_\_\_\_  
Signature Date Print Name Relationship To Child