

Lennie M. Checchio, DDS, LTD
Diplomate, American Board of Pediatric Dentistry
Michael A. Koumaras, DMD
9525 Frankford Avenue Philadelphia, PA 19114
215 - 333 - 9697
BestDentist4Kids.com

Whom May we thank for Referring you? _____

Please fill in the personal health history on the following pages. This information is an important aid in making a thorough evaluation of your child's dental health. It also allows us to more adequately plan for your child's emotional and dental needs. This important document therefore, becomes an integral part of our continuing evaluation of your child's growth and development in these formative years. This material is confidential. Thank you for your cooperation.

Child's Name: _____ Nickname: _____
Age: _____ Birth Date: _____ Phone: _____ Sex: M F
Address: _____ City: _____ State: _____ Zip: _____
Father's Name: _____ Birth Date: _____ Social Security # _____
Employer: _____ Occupation: _____ Cell # _____
Mother's Name: _____ Birth Date: _____ Social Security # _____
Employer: _____ Occupation: _____ Cell # _____

Names and ages of other Children _____
Family Dentist: _____

Dental Insurance Information

Primary Coverage:
Insured Name: _____ Social Security # _____ DOB _____
Place of employment: _____ Insurance Co.: _____
Insurance Co. ID #: _____ Group # _____ Phone # _____
Is policy connected with your union? If yes, name of union: _____ Local # _____
Do you have dual coverage? Yes[] No[] If yes please complete the secondary insurance information.
Insured Name: _____ Social Security # _____ DOB _____
Place of employment: _____ Insurance Co.: _____
Insurance Co. ID #: _____ Group # _____ Phone # _____

Is policy connected with your union? If yes, name of union: _____ Local # _____

Responsible Party Information

Name: _____ Social Security # _____ Birth Date: _____
Relationship to Patient: _____
Residence: _____ City: _____ State: _____
Zip: _____
Home Phone: _____ Work #: _____ Cell #: _____
Responsible Party Signature: _____

Medical History

Child's Physician _____ Address: _____ Phone: _____

Current Medical Conditions: _____

Current Medications and/or Medical Treatments: _____

Has your child ever been hospitalized? _____ If yes, Please give the details: _____

Any complications during your child's birth? _____

Medications taken during pregnancy _____

Check which of the following your child has had and at what age:

___ Measles(regular) Age: ___ ___ German Measles Age: ___

___ Chicken Pox Age: ___ ___ Whooping Cough Age: ___

___ Mumps Age: ___ ___ Broken Bones Age: ___

___ Pneumonia Age: ___ ___ Serious Accidents Age: ___

___ Scarlet Fever Age: ___ ___ Removal of Tonsils Age: ___

___ Removal of Adenoids Age: ___

Is there a History of any of the following:

___ Hearing Difficulties

___ Speech Difficulties

___ Emotional Difficulties

___ Fainting or Dizziness

___ Poor Vision

___ Liver disease _____

___ Hepatitis _____

___ Anemia

___ Asthma

___ Birth Defects

___ Rheumatic Fever

___ Kidney Disease

Is dialysis required? _____

___ Tuberculosis Age ___

___ Skin Problems _____

___ Bone and Joint Problems

___ Epilepsy/Seizures - Last incident _____

___ Cerebral Palsy

___ Disease affecting normal growth _____

___ Diabetes

___ Bleeding Problems _____

___ Heart Problem _____

is antibiotic pre-medication required? _____

___ Blood Transfusion? What year? _____

___ Other _____

___ Organ Transplant? Year _____

Has your child ever had an unfavorable reaction to local or general anesthesia? _____

If yes, please describe: _____

Allergies: ___ Penicillin ___ other drugs _____

___ Anesthetics ___ Foods _____

___ Other: _____

Is there a history of any of the following in the child's family? Please check which one (s):

___ Heart Disease ___ Tuberculosis ___ Birth defects ___ Sickle Cell anemia

___ Diabetes ___ Cancer ___ Kidney Disease ___ Liver Disease

___ Bleeding Problems ___ Hypertension ___ Congenitally Missing Teeth

Dental History

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

Were x-rays ever taken? _____ When? _____

Has your child had a previous unfavorable dental experience? _____

What is your main reason for bringing your child to this office? _____

Are you seeking complete quality dental health care for your child? _____

What type of fluoride has your child experienced?

In the community water? _____ Fluoride rinses? _____ Fluoride Tablets? _____

In the dental office? _____ Toothpaste? _____ Other supplements? _____

Is your community water fluoridated? _____

Does Your child have a history of any of the following?

Thumb or finger sucking? _____ Mouth breathing? _____ Fingernail biting? _____

Grinding of teeth? _____ Speech problems? _____ Tongue Thrusting? _____

Other? _____

Has your child had a history of any injury to the face or teeth? _____

Who brushes your child's teeth and how often? _____

Are you happy with your child's eating habits? _____

What would you like changed? _____

How would you describe your child's temperament? _____

Child's interests, hobbies, talents, etc? _____

Any questions you would like answered? _____

Because _____ is a minor, it is necessary for signed permission from a parent or guardian before any and /or all necessary dental services can be rendered. Furthermore, undersigned will be responsible for any fee incurred on the above child for dental treatment rendered.

This is my consent for initial dental examination, dental cleaning, topical fluoride treatment and necessary x-rays. This will also agree to the use of local anesthesia, nitrous oxide (laughing gas) if necessary for dental treatment. The use of these medications will be explained prior to their use.

Date: _____ Signed: _____

Relationship to child: _____