Penny Resnick-Graulich, D.M.D.,PC
Main Street Pediatric Dentistry
115 Main Street Suite 302
Tuckahoe, NY 10707
(914)633-4440

Date___________

Child's Name__________________________________ **M/ F**

Nick Name_________________________ Date of Birth________________

Home Phone________________________

Address___________________________ City________ State____ Zip____

Who May We Thank For Referring you to our office?

____

PATIENT INFORMATION

Father's Full Name_____________________________________

Employer____

Business Address____

Telephone______________________ Cell______________________________

Mother's Full Name_____________________________________

Employer____

Business Address______________________ Email_______________________

Telephone______________________ Cell ______________________________

Are you: Married Single Separated Widowed Divorced

Who is responsible for this account? _________________________________

Where may we call regarding your child's appointment?_____________________

CHILD'S HEALTH HISTORY

Reason for dental visit____

Family dentist____

Child's previous dentist/dental experience______________________________

Name of your child's physician____________________ Telephone____________

Date of last dental visit_________________________ Date of last X-rays______

Has there ever been a problem with dental care?__________________________

If so, please explain____

Have your child's teeth been injured in an accident?_______________________

Does your home have city water supply or well water?______________________

Does your child take fluoride supplements?_______________________________

Does your habit have a habit, such as thumb sucking, use of a pacifier, or nail biting, that may effect his/her teeth?____

Do you nurse or does your child take a bottle to sleep?_______________________

Do you help brush your child's teeth? ___________________________________

DOES YOUR CHILD HAVE ANY OR HISTORY OF THE FOLLOWING:

Y or N	Please answer	Y or N	
	Anemia		Hearing loss/Problems
	Asthma/Respiratory problems		Hepatitis
	Behavioral Disorder		HIV/AIDS
	Bleeding problems/Abnormal		Kidney or Liver Problems
	Cancer		Latex Allergy
	Congenial birth defects		Other
	Diabetes		Pre-medication Needed
	Ear/Nose/Throat problems		Rheumatic Fever
	Epilepsy seizure disorder		Skin Disorder
	Handicap or emotional problem		Speech/Vision problems
	Heart Condition/Heart Murmur		Tuberculosis

Your child's health is: Excellent Fair Poor

Is your child taking medication or vitamins at the present time? If so, what type?
____

Any other pertinent medical information or any unusual conditions?

Has your child ever been hospitalized or undergone surgery? If so, please explain.

Does your child have any known allergies? If so, please explain.

CHILD'S TEMPERMENT

Shy Fearful Easygoing Calm Outgoing Manipulative

How do you think your child act during dental treatment?

Is there anything else you would like us to know about your child?

How has your child's experience been with other doctors?

OTHER INFORMATION

Names and ages of brothers and sister: _____________________________________

Hobbies, pets, favorite TV shows, etc:_______________________________________

TO THE BEST OF MY KNOWLEDGE THE INFORMATION PROVIDED IS ACCURATE AND COMPLETE AND IF THERE IS A CHANGE IN MY CHILD'S HEALTH OR MEDICATIONS, I WILL INFORM THE DOCTOR. THE PARENT/GUARDIAN WHOSE SIGNATURE APPEARS BELOW CONSENTS TO TREATMENT AS EXPLAINED TO THEM BY DR. RESNICK-GRAULICH OR DENTAL PROFESSIONALS AND IS RESPONSIBLE FOR ALL FEES AT THE TIME SERVICES ARE RENDERED.

SIGNATURE____ DATE___________________

PATIENT HIPAA AWARENESS

With my permission, Dr. Penny Resnick-Graulich, Main Street Pediatric Dentistry may use and disclose protected health information (PHI) about the patient indicated below to carry out treatment, payment and healthcare operations (TPO). Please refer to Dr. Penny Resnick-Graulich's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Dr. Penny Resnick-Graulich reserves the right to revise her Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to the office.

With my permission, the office of Dr. Penny Resnick-Graulich may call my home or other designated location(s) and leave a message on voice mail or in person in reference to any items that assist the practice to carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care.

With my permission, the office of Dr. Penny Resnick-Graulich may email to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements. I have the right to request that Dr. Resnick-Graulich restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my required to agree to my requested restrictions, but if it des, it is bound by this agreement.

By signing this, I am allowing Dr. Resnick-Graulich, Main Street Pediatric Dentistry to use and disclose my PHI for TPO.

I may revoke my consent in writing except to the extent that the practice has already make disclosures in reliance upon my prior consent.

Signature of Legal Guardian   Printed Name and Relationship

Print Patient Name