Magic Smiles for kids
PEDIATRIC DENTISTRY

826 Buffalo Avenue
Lindenhurst, NY 11757
(631) 226-5437

Confidential Questionnaire

Welcome to our office. The first step towards providing you with the best dental care is to complete the following forms as accurately as possible. Please print your responses legibly.

Patient's First Name:_____ Patient's Last Name:_____ M.I.___

Patient's Date of Birth:____/____/____ Age:_____ Male/Female

Home Address:

Street:_____

City, State, Zip:_____

Mother's: First Name:_____ Last Name:_____ Cell Phone:_____

Father's: First Name:_____ Last Name:_____ Cell Phone:_____

Home Phone:_____ E-Mail Address:_____

Primary Insurance Information

Insured's Name:_____ Relationship to Patient:_____

Insured's Social Security Number:_____ Insured's Date of Birth:____/____/____

Insurance Name:_____ Group Number:_____

Secondary Insurance Information

Insured's Name:_____ Relationship to Patient:_____

Insured's Social Security Number:_____ Insured's Date of Birth:____/____/____

Insurance Name:_____ Group Number:_____

How did you hear about our office? _____

What is the reason for your visit today? _____

When was the patient's last dental visit? _____

Patient Name: _____

Please circle Yes or No when answering the following questions:

Are you in good health?	Yes	No
Are you taking any medications presently?	Yes	No
If yes, please indicate which medications _____		
Do you have any allergies to any medications or foods?	Yes	No
If yes, please indicate _____		
Have you been a patient at a hospital in the past five years?	Yes	No
If yes, please indicate the reason _____		

Pediatrician Name: _____ Pediatrician Phone Number: _____

Please indicate which of the following you have had or presently have:

Latex Sensitivity	Yes	No	Bruising/Excessive Bleeding	Yes	No
Asthma	Yes	No	Tumors	Yes	No
Breathing Problems	Yes	No	Chemotherapy	Yes	No
Bronchitis	Yes	No	Radiation Therapy	Yes	No
Sinus Trouble	Yes	No	Hepatitis	Yes	No
Diabetes	Yes	No	Herpes	Yes	No
Heart Murmur	Yes	No	Cold Sores/Fever Blisters	Yes	No
Aortic Stenosis	Yes	No	Arthritis	Yes	No
Congenital Heart Condition	Yes	No	Thyroid Disease	Yes	No
Heart Surgery	Yes	No	Liver Disease	Yes	No
Kidney Problems	Yes	No	Tuberculosis	Yes	No
Kidney Transplant	Yes	No	Epilepsy/Seizures	Yes	No
Ulcers	Yes	No	ADD	Yes	No
Blood Diseases	Yes	No	ADHD	Yes	No
Hemophilia	Yes	No	Autism	Yes	No
Blood Transfusions	Yes	No	Asperger's Syndrome	Yes	No
HIV Positive	Yes	No	Other _____		

Dental History

Has your child ever had an unfavorable reaction to a local anesthetic?	Yes	No
Has your child had any serious trouble associated with previous dental treatment?	Yes	No
Has your child had any form of sedation for dental treatment?	Yes	No
If yes, which kind of sedation? _____		
Does your child grind his/her teeth?	Yes	No
Does your child suck his/her thumb?	Yes	No

Please read thoroughly before signing

I have filled out this questionnaire accurately. It is my responsibility to inform your office of any changes. I realize that the fina
agreements in regard to dental insurance are estimates based on available information at the time of eligibility verification and tha
ultimately responsible for all the charges incurred as a result of my child's dental treatment. Also, all emergency dental services,
service performed without prior financial agreement, or insurance verification, is due at the time of service. I also understand tha
a charge for failure to cancel an appointment without 24 hour notice.

Signature _____ Date _____

Doctor's Signature _____ Date _____

Dental Health Certificate- Optional

Parent/Guardian: New York State law (Chapter 281) permits schools to request an oral health assessment in the following grades: school entry, K, 2, 4, 7, & 10. Your child may have a dental check-up during this school year to assess his/her fitness to attend school. Please complete Section 1 and take the form to your registered dentist or registered dental hygienist for an assessment. If your child had a dental check-up before he/she started the school, ask your dentist/dental hygienist to fill out Section 2. Return the completed form to the school's medical director or school nurse as soon as possible.

Section 1. To be completed by Parent or Guardian (Please Print)

Child's Name: Last First Middle

Birth Date: / / Month Day Year

Sex: ⇨ Male ⇨ Female

Will this be your child's first oral health assessment ? ⇨ Yes ⇨ No

School: Name

Grade

Have you noticed any problem in the mouth that interferes with your child's ability to chew, speak or focus on school activities? ⇨ Yes ⇨ No

I understand that by signing this form I am consenting for the child named above to receive a basic oral health assessment. I understand this assessment is only a limited means of evaluation to assess the student's dental health, and I would need to secure the services of a dentist in order for my child to receive a complete dental examination with x-rays if necessary to maintain good oral health.

I also understand that receiving this preliminary oral health assessment does not establish any new, ongoing or continuing doctor-patient relationship. Further, I will not hold the dentist or those performing this assessment responsible for the consequences or results should I choose NOT to follow the recommendations listed below.

Parent's Signature _____ Date _____

Section 2. To be completed by the Dentist/ Dental Hygienist

I. The dental health condition of _____ _____ on_____ (date of assessment)
The date of the assessment needs to be within 12 months of the start of the school year in which it is requested. Check one:

☐ Yes, The student listed above is in fit condition of dental health to permit his/her attendance at the public schools.

☐ No, The student listed above is not in fit condition of dental health to permit his/her attendance at the public schools.

NOTE: Not in fit condition of dental health means that a condition exists that interferes with a student's ability to chew, speak or focus on school activities including pain, swelling or infection related to clinical evidence of open cavities. The designation of not in fit condition of dental health to permit attendance at the public school does not preclude the student from attending school.

Dentist's/ Dental Hygienist's name and address

(please print or stamp)

Dentist's/Dental Hygienist's Signature

Optional Sections - If you agree to release this information to your child's school, please initial here. ☐

II. Oral Health Status (check all that apply).

⇨ Yes ⇨ No **Caries Experience/Restoration History** – Has the child ever had a cavity (treated or untreated)? [A filling (temporary/permanent) OR a tooth that is missing because it was extracted as a result of caries OR an open cavity].

⇨ Yes ⇨ No **Untreated Caries** – Does this child have an open cavity? [At least ½ mm of tooth structure loss at the enamel surface. Brown to dark-brown coloration of the walls of the lesion. These criteria apply to pits and fissure cavitated lesions as well as those on smooth tooth surfaces. If retained root, assume that the whole tooth was destroyed by caries. Broken or chipped teeth, plus teeth with temporary fillings, are considered sound unless a cavitated lesion is also present].

⇨ Yes ⇨ No **Dental Sealants Present**

Other problems (Specify):_____

II. Treatment Needs (check all that apply)

⇨ No obvious problem. Routine dental care is recommended. Visit your dentist regularly.

⇨ May need dental care. Please schedule an appointment with your dentist as soon as possible for an evaluation.

⇨ Immediate dental care is required. Please schedule an appointment immediately with your dentist to avoid problems.

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Office Visit Consent Authorization

I, _____ authorize the following people to accompany, discuss and make all necessary decisions in regards to dental treatment for following pt; (Patient Name & D.O.B)_____.

1._____ Relationship to Patient _____.

2._____ Relationship to Patient _____.

3._____ Relationship to Patient _____.

4._____ Relationship to Patient _____.

5._____ Relationship to Patient _____.

Signature: _____

Relationship to patient: _____

Date_____

NOTE:PHOTO ID IS REQUIRED FOR EACH PERSON AT THE TIME OF THE VISIT.