Washington Township Dental
50 Years of Family Care

New Pediatric Patient Information

Mary-Kathyrn Annuzzi D.M.D.
Annie Creato D.M.D.

474 Hurfville-Crosskeys Road
Atrium One, Suite A - Sewell, NJ 08080
856-582-1000

Patient Information

Child's Full Name *(last, first, middle)*: _____ Nickname:_____

Gender: ❑M ❑F Date of Birth: _____ Child's favorite cartoon: _____

Are they enrolled in school? ❑Y ❑N School Name: _____ What grade?_____

Patient's Home #: _____ Email address: _____ SS#:_____

Patient's Home Address: _____

City: _____ State:_____ Zip:_____

How did you hear about our office? _____

Who is the adult accompanying the patient today? Do you have legal custody of this chid? ❑Y ❑N

Name: _____ Relationship: _____

Mother's Information

Name *(last, first, middle)*: _____ ❑Mother ❑Stepmother ❑Guardian

Employer: _____ Work#:_____ ext:_____

Home #: _____ Cell: _____Email address: _____

Patient's Home Address: _____

City: _____ State:_____ Zip:_____

SS#: _____ Driver Lic#: _____

Father's Information

Name *(last, first, middle)*: _____❑Father ❑Stepfather ❑Guardian

Employer: _____ Work#:_____ ext:_____

Home #: _____ Cell: _____Email address: _____

Patient's Home Address: _____

City: _____ State:_____ Zip:_____

SS#: _____ Driver Lic#: _____

Primary Insurance Information

Insurance Company (IC) Name:_____

IC Address: _____ City: _____ State:_____ Zip:_____

IC Phone #: _____ Group# (*Plan, Local or Policy#*):_____

Policy Holder's Name: _____ Relationship to Patient:_____

Policy Holder's DOB: _____ SS#:_____ Employer:_____

Secondary Insurance Information

Insurance Company (IC) Name:_____

IC Address: _____ City: _____ State:_____ Zip:_____

IC Phone #: _____ Group# (*Plan, Local or Policy#*):_____

Policy Holder's Name: _____ Relationship to Patient:_____

Policy Holder's DOB: _____ SS#:_____ Employer:_____

The above information is accurate and complete to the best of my knowledge. Any errors or omissions in completing this form are solely my responsibility. We reserve the right to charge for appointments cancelled or failed without 24 hours advance notice. Weekdays after 4PM and Saturdays will automatically be charged. Payment is due in full at time of treatment unless prior arrangements have been approved. **Balances unpaid after 90 days are subject to a late charge of 1.5% per month,** and may be reported to the credit bureaus at our discretion. I understand that by signing below I accept financial responsibility for all charges whether or not paid by insurance.

Signature of person responsible	*Relationship to Patient*	*Date*

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HIPAA

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HIPAA OMNIBUS RULE - Patient acknowledgement of receipt of notice of privacy practices and consent/limited authorization & release form.
You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges having had full opportunity to read and consider the contents of this HIPAA Consent form and the Notice of Privacy Practices. The undersigned understands that, by signing this consent form, they are giving consent to use and disclose their protected health information to carry out treatment, payment activities, insurance and any other office procedures. A copy of this signed, dated document shall be as effective as the original. MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS/FACILITIES IN THE FUTURE.

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide this information with your knowledge and consent.

Please print patient's name	Patient Signature (if 18 or older)
Parent / Guardian / Legal Representative Signature	Description of Authority

☑ How do you want to be addressed when summoned from the reception area? ❑First Name Only ❑Proper Sir Name ❑Other: _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:
(This includes step parents, grandparents and any caretakers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

☑ I AUTHORIZE contact from this office to **confirm my appointments, treatment and billing information** via:
❑ Cell Phone ❑ Home Phone ❑ Work Phone ❑ Text Message My Cell Phone ❑ Email Confirmation ❑ Any of the Above

☑ I AUTHORIZE contact from this office to **information about my health** via:
❑ Cell Phone ❑ Home Phone ❑ Work Phone ❑ Text Message My Cell Phone ❑ Email Confirmation ❑ Any of the Above

☑ I APPROVE being contacted about **special services, events, fund raising efforts or new heath info** on behalf of this healthcare facility via:
❑ Phone Message ❑ Text Message ❑ Email Confirmation ❑ Any of the Above ❑ None of the Above (opt out)

Your comments regarding Acknowledgement or Consents: _____

_____

_____

Office Use Only *As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgement, but did not because:*

❑ It was an emergency treatment
❑ I could not communicate with the patient
❑ The patient refused to sign
❑ The patient was unable to sign because: _____
❑ Other (please describe): _____

Signature of Privacy Officer: _____

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Pediatric Medical History

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Child's Full Name: _____ Nickname: _____

Address: _____ Email: _____

Gender: ❑M ❑F Tel: _____ Cell: _____ Parent SS#: _____

Date of Birth: _____ Height: _____ Weight: _____ Date of Last Physical: _____

Primary Physician: Name/ Address/ Phone _____

Medical Specialists: Name/ Address/ Phone _____

☑ Is your child up to date on immunizations against childhood diseases? ..... ❑Y ❑N

☑ Is your child taking any medication, vitamins, or dietary supplements? ..... ❑Y ❑N

List name, dose, how often, start date _____

☑ Has your child ever had a serious injury/surgery or been hospitalized/ER? ..... ❑Y ❑N

List date and describe _____

☑ Has your child ever had a reaction to or problem with an anesthetic? ..... ❑Y ❑N

☑ Has your child ever had a reaction or allergy to an antibiotic or other medication? ..... ❑Y ❑N

☑ Is your child allergic to Latex, foods, dyes, or anything else? ..... ❑Y ❑N

☑ Is your child up to date on immunizations against childhood diseases? ..... ❑Y ❑N

Please mark ☑ Y for "yes" if an item below pertains to your child or mark ☑ N for "no" if the item does not apply to your child.

❑Y	❑N	Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions
❑Y	❑N	Problems with physical growth or development, weight, or history of eating disorder
❑Y	❑N	Sinusitis, chronic adenoid/tonsil infections
❑Y	❑N	Sleep apnea/snoring, mouth breathing, or excessive gagging
❑Y	❑N	Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease
❑Y	❑N	Irregular heart beat or high blood pressure
❑Y	❑N	Asthma, reactive airway disease, wheezing, or breathing problems
❑Y	❑N	Cystic fibrosis
❑Y	❑N	Frequent colds or coughs, or pneumonia
❑Y	❑N	Frequent exposure to tobacco smoke
❑Y	❑N	Jaundice, hepatitis, or liver problems
❑Y	❑N	Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems
❑Y	❑N	Bladder or kidney problems
❑Y	❑N	Arthritis, scoliosis, limited use of arms or legs, or muscle/ joint/ bone problems
❑Y	❑N	Rash/hives, eczema, or skin problems
❑Y	❑N	Impaired vision, hearing, or speech
❑Y	❑N	Developmental disorders, learning problems/delays, or intellectual disability
❑Y	❑N	Cerebral Palsy, brain injury, epilepsy, or seizures
❑Y	❑N	Autism/ autism spectrum disorder
❑Y	❑N	Recurrent/ frequent headaches/ migraines, fainting, or dizziness
❑Y	❑N	Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous)
❑Y	❑N	Attention deficit/hyperactivity disorder (ADD/ADHD)
❑Y	❑N	Behavioral, emotional, communication, or psychiatric problems/treatment
❑Y	❑N	History of known abuse (physical, psychological, emotional, or sexual) or neglect
❑Y	❑N	Diabetes, hyperglycemia, or hypoglycemia
❑Y	❑N	Precocious puberty or hormonal problems
❑Y	❑N	Thyroid or pituitary problems
❑Y	❑N	Anemia, sickle cell disease/trait, or blood disorder
❑Y	❑N	Hemophilia, bruising easily, or excessive bleeding
❑Y	❑N	Transfusions or receiving blood products
❑Y	❑N	Cancer, tumor, chemotherapy, radiation therapy, or bone marrow or organ transplant
❑Y	❑N	Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus, methicillin resistant staphylococcus aureas (MRSA), sexual transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS

Provide details for any "Yes" responses above: _____

Is there any other medical history pertaining to this child or his/her family? _____

What is your primary concern about your child's oral health?

Your child's oral health is... ❑Excellent ❑Good ❑Fair ❑Poor

☑ Do any of the following apply to your child? For each "yes" please describe:

Family history of cavities (who).....❑Y ❑N

Inherited dental characteristics .....❑Y ❑N

Mouth sores or fever blisters.....❑Y ❑N

Bad breath.....❑Y ❑N

Cavities/decayed teeth.....❑Y ❑N

Toothache.....❑Y ❑N

Injury to teeth, mouth, or jaws.....❑Y ❑N

Clenching/grinding.....❑Y ❑N

Jaw/ Joint problems (popping etc.) .....❑Y ❑N

Excessive gagging.....❑Y ❑N

Sucking habit after 1 year of age.....❑Y ❑N ❑Pacifier ❑Thumb ❑Finger ❑Other What age did they stop?

☑ How often does your child brush their teeth?

Does someone help them? ❑Y ❑N

☑ How often does your child floss their teeth?

Does someone help them? ❑Y ❑N

☑ What toothpaste does your child use?

☑ Source of the drinking water at home? ❑City/ Community ❑Private well

Do you use a water filter? ❑Y ❑N Type:

☑ Does your child receive any fluoride sources?

❑Over the counter rinse ❑School fluoride program

❑Pediatrician applied fluoride ❑Prescription fluoride toothpaste

❑Prescription drops/tablets/ vitamins

☑ How frequently does your child have the following?

Candy or other sweets ❑Rarely ❑1-2/day ❑3 or more/day

Products:

Chewing Gum ❑Rarely ❑1-2/day ❑3 or more/day

Type:

Snacks between meals ❑Rarely ❑1-2/day ❑3 or more/day

Usual snack

Soft drinks* ❑Rarely ❑1-2/day ❑3 or more/day

Products

*(*juice, fruit flavored drinks, sodas, sweetened beverages, sports drinks, or energy drinks)*

Any other significant dietary habits?

☑ Is your child on a special or restricted diet? ❑Y ❑N

Describe:

☑ Does your child have a diet high in sugars or carbohydrates? ❑Y ❑N

Describe:

☑ Do you have any concerns regarding your child's weight? ❑Y ❑N

Describe:

☑ Does your child participate in any sports or similar activities? ❑Y ❑N

☑ Does your child wear a mouthguard during these activities? ❑Y ❑N

☑ Has your child been examined or treated by another dentist? ❑Y ❑N

Date of last visit? Were x-rays taken?

Date of last x-rays?

☑ Has your child ever been evaluated by an orthodontist? ❑Y ❑N

When? Any orthodontic treatment done?

☑ Has your child ever had a difficult dental appointment? ❑Y ❑N

Describe:

Is there anything else we should know before treating your child?

The information on both sides of this form is accurate and complete to the best of my knowledge. Any errors or omissions in completing this form are solely my responsibility.

Signature of parent/guardian | *Relationship to Patient* | *Date*

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Email: Washingtontownshipdental@gmail.com

Pediatric Dentistry:
Mary-Kathryn Annuzzi D. M. D.
Annie Creato D. M. D.

Additional Pediatric New Patient History (Initial Visit Only)

Supplemental History Questions for Infant/Toddler (4 and under):

Was your child born prematurely? **__ YES __NO**

If YES, What Week? _____ Weight? _____

How long was your child breast-fed?

__ N/A __less than 6 months __6-11 months __12-17 months __ 18-23 months __ 2 years/more

How long did your child bottle feed?

__ N/A __less than 6 months __6-11 months __12-17 months __ 18-23 months __ 2 years/more

Do/did you feed your child infant formula? **__YES __ NO**

Does/did your child sleep with a bottle? **__YES __ NO**

Does/did your child use a no-spill training cup (sippy cup)? **__YES __ NO**

Child's age (in months) when first tooth appeared in mouth? _____

Has your child experienced any teething problems? **__YES __ NO**

When did you begin brushing his/her teeth?

__ N/A __less than 6 months __6-11 months __12-17 months __ 18-23months __ 2 years/more

When did you begin using toothpaste?

__ N/A __less than 6 months __6-11 months __12-17 months __ 18-23months __ 2 years/more

Who is your child's primary care taker during the day? _____Evening? _____

Name/age siblings at home _____

Print Name of Parent Guardian _____ Relationship to child _____

Signature of Parent/Guardian _____ (Date) _____/_____/_____