CENTRAL PARK WEST PEDIATRIC DENTISTRY
327 Central Park West
New York, New York, 10025
212 280-1700

Today's Date____________________

Patient's Name______________________________ Age_____ Birth Date__________

Male ☐ Female ☐

Patient's Address: ______________________________ Zip Code__________

Names and Ages of Sibling:______________________________

Hobbies, Pets, Nickname:______________________________ School__________________

Parent

Name______________________________ Date of Birth__________________ Social Security #__________________

Home Address____________________ Zip Code__________ Residence Phone__________________

Email Address______________________________ Cell #__________________

Occupation__________ Company Name__________________ Business Phone__________________

Parent

Name______________________________ Date of Birth__________________ Social Security #__________________

Home Address____________________ Zip Code__________ Residence Phone #__________________

Email Address______________________________ Cell #__________________

Occupation__________ Company Name__________________ Business Phone #__________________

Marital Status of Parents______________________________

Please let us know what your preferred method of contact is:

Text Msg/Cell__________________ Phone__________________ Email__________________

Family Nanny

Name______________________________ Cell #__________________

WHOM MAY WE THANK FOR REFERRING YOU?

Name______________________________ Address__________________

PAYMENT INFORMATION

Credit Card Name__________________ No.__________________ Expiration Date__________

Name of Dental Insurance______________________________ Group and ID#__________________

Name of Primary Plan Holder______________________________ Birth Date__________________

Dental Insurance Telephone #______________________________

Dental Insurance Claims Mailing Address______________________________ Zip Code__________

NOTE: CENTRAL PARK WEST PEDIATRIC DENTISTRY DOES NOT PARTICIPATE WITH DENTAL INSURANCE PLANS. AS A COURTESY WE WILL SUBMIT A CLAIM TO YOUR INSURANCE FOR REIMBURSEMENT.

DENTAL HISTORY

Is this your child's first trip to the dentist?___________________________________

In no, please give us the date of the last visit and the name of the dentist.

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Please tell us why you are here (routine visit, emergency or other immediate concerns)_________________________

____

Has your child ever been treated for dental injury, toothache, or other emergency ?

____

How has your child behaved during previous dental treatment (if applicable)?_____________________________

____

MEDICAL HISTORY

Pediatrician/Physician_______________________ Address and Phone___________________________________

Please state any medical, emotional, or behavioral condition that your child has or is suspected of having.

Please be specific ____

Does your child take any medication? If so, please state name and dosage if known:

____

Does your child have any allergies to medication? If so, please state_________________________________

Does your child have any LATEX allergies? If so, please state____

Does your child have any food or seasonal allergies? If so, please state________________________________

Have you ever been told that your child has a heart murmur?________________ If yes, do they require antibiotic premedication before a dental visit?________________

PLEASE CHECK ANY CONDITION THAT APPLIES TO YOUR CHILD:

- ☐ Bleeding Disorders
- ☐ Heart Disease
- ☐ Gastro Intestinal Disease
- ☐ Asthma
- ☐ AIDS
- ☐ Seizures
- ☐ Neurologic Disorders
- ☐ Urinary Tract Disorders
- ☐ History of Surgery
- ☐ Diabetes
- ☐ Arthritis
- ☐ Liver Disorders
- ☐ Kidney Disease
- ☐ Sickle Cell Disease
- ☐ Learning Disorders
- ☐ Possibility of Pregnancy
- ☐ Blood Transfusions
- ☐ Premature Birth

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Signature of Parent/Guardian___________________________ Relationship______________________ Date__________

The parent/guardian whose signature appears above is responsible for all fees when services are rendered and consents to treatment as explained to them by the dentist or dental professional.

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