Welcome

LAKE PLACID™ FAMILY DENTAL
DAVID BALESTRINI, DMD

Today's Date _____

Patient Information for a Minor (confidential)

_____Male _____Female

Date of Birth _____

Patient Name_____Nickmame_____Home Phone_____

Mailing Address_____City_____State___Zip_____

Physical Address(if different)_____City_____State___Zip_____

Child's Cell Phone _____ School Name _____ Grade _____

Patient lives with: ☐ Mom ☐ Dad ☐ Mom and Dad ☐ Other: _____

Responsible Party (Parent or Legal Guardian who will schedule appointments, accompany minor to appointments, make treatment decisions, and who is responsible for patient account)

Name _____ Relationship to Patient _____

Mailing Address_____City_____State___Zip_____

Physical Address(if different)_____City_____State___Zip_____

Home Phone _____ Cell Phone _____ Email_____

Employer _____ City _____ State _____ Zip _____

Social Security # _____ Driver's License # _____State of Licensure _____

Emergency Contact _____ Relationship _____ Phone _____

Name of person, office or other source referring patient to our practice _____

☐ Patient ☐ Doctor's Office ☐ Website ☐ Signage ☐ Yellow Pages ☐ Other _____

I prefer to receive my child's appointment reminder calls at:

☐Home ☐Work ☐Cell Other: _____ ☐ Any of the listed numbers

Dental Insurance Information (Subscriber is: person who holds the insurance)

Name of Subscriber_____Relationship to Patient_____

Subscriber's Birth Date_____Subscriber's ID#_____

Insurance Carrier Name_____Employer Sponsoring Insurance_____

Insurance Carrier Address_____

Insurance Carrier Phone_____Group#_____

Additional Dental Insurance (If Applicable)

Name of Subscriber_____Relationship to Patient_____

Subscriber's Birth Date_____Subscriber's ID#_____

Insurance Carrier Name_____Employer Sponsoring Insurance_____

Insurance Carrier Address_____

Insurance Carrier Phone_____Group#_____

I authorize release of any information concerning my child's health care, service and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor's office. I authorize use of my signature on all insurance claims.

Signature of Responsible Party X_____ Date _____

Patient Medical History

Physician _____ Office Phone_____ Date of Last Exam_____

	Yes	No
Are you under medical treatment now?.....	☐	☐
Have you been hospitalized for any surgical operation or serious illness within the last 5 years?	☐	☐
If yes, please explain _____		
Are you taking any prescribed or OTC Medications, Vitamins or Herbal Supplements? Please list or attach.....	☐	☐
_____		
_____		
_____		
_____		
Do you smoke or chew tobacco?.....	☐	☐

Are you allergic to or have you had any reactions to the following?	Yes	No
Local Anesthetics(e.g. novocaine).....	☐	☐
Penicillin or other Antibiotics.....	☐	☐
Sulfa Drugs.....	☐	☐
Barbiturates, Sedatives or Sleeping Pills.....	☐	☐
Codeine or other Narcotics.....	☐	☐
Iodine.....	☐	☐
Aspirin.....	☐	☐
Any metals(e.g.nickel).....	☐	☐
Latex Rubber.....	☐	☐
Other(please list) _____	☐	☐

Do you have or have you had any of the following?

	Yes	No		Yes	No		Yes	No
High Blood Pressure.....	☐	☐	Heart Disease.....	☐	☐	Easily Winded.....	☐	☐
Heart Attack.....	☐	☐	Cardiac Pacemaker.....	☐	☐	Eating Disorder.....	☐	☐
Stroke.....	☐	☐	Heart Murmur.....	☐	☐	Hay Fever/Allergies.....	☐	☐
Swollen Ankles.....	☐	☐	Angina/Chest Pains.....	☐	☐	Tuberculosis.....	☐	☐
Fainting/Seizures.....	☐	☐	Blood Transfusion.....	☐	☐	Rheumatic Fever.....	☐	☐
Asthma.....	☐	☐	Anemia.....	☐	☐	Glaucoma.....	☐	☐
Low Blood Pressure.....	☐	☐	Emphysema.....	☐	☐	Recent Weight Loss.....	☐	☐
Epilepsy/Convulsions.....	☐	☐	Cancer.....	☐	☐	Liver Disease.....	☐	☐
Leukemia.....	☐	☐	Chemo or Radiation Therapy.....	☐	☐	Osteoporosis/Osteopenia....	☐	☐
Diabetes.....	☐	☐	Joint Replacement or Implant.....	☐	☐	Respiratory Problems.....	☐	☐
Kidney Diseases.....	☐	☐	Hepatitis/Jaundice.....	☐	☐	Mitral Valve Prolapse.....	☐	☐
AIDS or HIV Infection.....	☐	☐	Arthritis.....	☐	☐	Fibromyalgia.....	☐	☐
Thyroid Problem.....	☐	☐	Stomach Troubles/Ulcers/GERD...	☐	☐	Sinus Trouble.....	☐	☐
			Prolonged or Abnormal Bleeding..	☐	☐	Other_____	☐	☐

Patient Dental History

Name of Previous Dentist and Location _____ Date of Last Exam _____

Do you have or have you had any of the following:

	Yes	No
Bleeding Gums?.....	☐	☐
Sensitive Teeth?.....	☐	☐
Tooth Pain?.....	☐	☐
Sores/Lumps in Mouth?.....	☐	☐
Dry Mouth?.....	☐	☐
Have you had any head, neck or jaw injuries?.....	☐	☐
Do you have a dry mouth?.....	☐	☐
Have you had any jaw problems:	☐	☐
Clicking?.....	☐	☐
Pain(joint, ear, side of face)?.....	☐	☐
Difficulty in opening or closing?.....	☐	☐
Difficulty in chewing?.....	☐	☐
Do you have frequent headaches?.....	☐	☐
Do you clench or grind your teeth?.....	☐	☐
Do you bite your lips or cheeks habitually?.....	☐	☐

	Yes	No
Have you ever had any difficult extractions?.....	☐	☐
Prolonged bleeding after extractions?.....	☐	☐
Problems with Past Treatment?.....	☐	☐
Local Anesthetic?.....	☐	☐
Dental Sealants?.....	☐	☐
Oral Hygiene Instructions?.....	☐	☐
Orthodontics/Braces?.....	☐	☐
Are you taking Fluoride Supplements?.....	☐	☐
Are you using a Fluoride Toothpaste?.....	☐	☐
Is this your first dental visit?.....	☐	☐
Do you like the color of your teeth?.....	☐	☐
Do you like your smile? If no, what would you change?_____	☐	☐
On a scale from 1-10 (10 being the highest level), rate your level of anxiety at dental visits. _____		

Authorization and Release

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. I understand that I am responsible for keeping Dr. Balestrini and team updated on changes in my child's health and medications at each dental visit.

I am the parent/legal guardian (please circle one) of _____ (please print name of child/minor) and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform the necessary dental services for the child named above, including, but not limited to x-rays, fluoride treatments, and the administration of anesthetics, which are deemed advisable by the doctor.

_____ _____

Signature of Parent or Legal Guardian Date

_____ _____

Please Print Name of Parent or Legal Guardian Relationship to Patient

_____ _____

Doctor Signature Date