



Vincent Vissichelli, DMD
Board Certified Pediatric Dentist

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Chart # _____
Health Alerts _____

Patient Information and Health History Form

Child's Name: _____ Nickname: _____ Date of Birth: _____
Street Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ Cell Phone: _____
SS#: _____ - _____ - _____ Sex: M or F (circle) Age: _____

Email: _____

Father/Legal Guardian: _____ Relation to Patient: _____
(If not same as Patient above) Street Address: _____
City: _____ State: _____ Zip: _____ Employer: _____
Phone: Work: _____ Cell: _____ Does this person have custody? Y or N
SS#: _____ - _____ - _____ (for policy holder/ responsible party) Marital Status: _____

Mother/Legal Guardian: _____ Relation to Patient: _____
(If not same as Patient above) Street Address: _____
City: _____ State: _____ Zip: _____ Employer: _____
Phone: Work: _____ Cell: _____ Does this person have custody? Y or N
SS#: _____ - _____ - _____ (for policy holder/ responsible party) Marital Status: _____

Person Responsible for payment on account: _____
Dental Insurance? Y or N (circle) If Yes, Insurance Company: _____
Member ID#: _____
How did you hear about us? _____

Medical/ Dental History

Is this your child's first dental visit? Y or N Name of previous Dentist/ Practice: _____
What is your chief concern/ reason for today's visit? _____
Yes or No Does your child have any oral habits? (ex. grinding, pacifier, finger sucking) _____
Yes or No Is your child in good health? If no, please explain: _____
Yes or No Is your child allergic to *anything*? If yes, please list: _____
Yes or No Has your child been hospitalized or had any surgeries? If so, please explain: _____
Yes or No Is your child currently taking any prescribed or over-the-counter medications? Please give name of medication and reason: _____

Please check if your child has been treated for any of the following?

- | | | |
|--|--|---|
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Problems at birth | <input type="checkbox"/> Liver/ GI Disease | <input type="checkbox"/> Kidney disease |
| <input type="checkbox"/> Speech/ hearing | <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Tonsil/ Adenoids |
| <input type="checkbox"/> Skin/ Eczema | <input type="checkbox"/> Cancer/ Tumors | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Bleeding/ Transfusions Anemia | <input type="checkbox"/> Seizures | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Sleep | <input type="checkbox"/> Congenital birth defects |
| <input type="checkbox"/> Asthma/ Breathing | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Cleft lip/ palate | <input type="checkbox"/> Endocrine/ growth | <input type="checkbox"/> Autism |
| <input type="checkbox"/> Mental delays | <input type="checkbox"/> Physical delays | <input type="checkbox"/> Other problems |

Please explain all items checked: _____

Yes or No **Does your child have any special need or is there anything you feel that we should know before providing dental care?** _____

Legal Consent

I give my permission for the following individuals to bring my child to the dentist:

1. **Name** _____ **Relationship** _____ **Phone #** _____
2. **Name** _____ **Relationship** _____ **Phone #** _____
3. **Name** _____ **Relationship** _____ **Phone #** _____

I am fully aware that the treatment and fees may change and payment is expected in full at the time of service. The treatment plan has been explained to me and the office staff has answered all questions. I also give Dr. Vissichelli and staff permission to consent to protective stabilization in a papoose board if necessary. I also understand that I may need to be reached by phone while my child is in the dental office.

Consent for Dental Treatment

I am the parent/ legal guardian or personal representative of the patient and there are no court orders now in effect that prevent me from signing consent. The information listed on this form is complete and accurate. I give consent for Dr. Vincent Vissichelli and Associates and staff to perform a dental examination, dental prophylaxis, fluoride treatment, X-rays and dental treatment on my child and file insurance claims directly with the insurance on file.

I understand that it is my responsibility to inform Firehouse Kid's Dentistry of any changes in my child's medical status. I understand that proposed treatment plans show only estimated amount of the co-payment and any balance not paid for by my insurance is the policy holders or parents responsibility. The information above is correct to the best of my knowledge.

Print Name: _____ **Date:** _____

Signature: _____