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?

☐ Heart Disease	☐ Heart murmur	☐ Tuberculosis
☐ Problems at birth	☐ Liver/ GI Disease	☐ Kidney disease
☐ Speech/ hearing	☐ Cerebral Palsy	☐ Tonsil/ Adenoids
☐ Skin/ Eczema	☐ Cancer/ Tumors	☐ Sickle Cell Anemia
☐ Bleeding/ Transfusions Anemia	☐ Seizures	☐ Rheumatic Fever
☐ Headaches	☐ Sleep	☐ Congenital birth defects
☐ Asthma/ Breathing	☐ Diabetes	☐ Hepatitis
☐ Cleft lip/ palate	☐ Endocrine/ growth	☐ Autism
☐ Mental delays	☐ Physical delays	☐ 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 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: _____