



Vincent Vissichelli, DMD
Board Certified Pediatric Dentist

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Chart # _____
Health Alerts _____

Email: _____

Patient Information and Health History Form

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

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#: _____
Whom can we thank for referring you to us/ 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 | <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 needs or is there anything you feel that we should know before providing dental care? _____

Consent for pediatric management techniques.

I understand that to provide the best possible dental care the dentist may elect to use any one or a combination of the presented techniques:

1. Voice control through firmness or lowering voice volume.
2. Mouth props (tooth pillow) to aid in keeping the mouth open.
3. Physical restraint by dentist, assistant or parent.

If you or your spouse objects to any of the above techniques you should inform the dentist or assistant prior the start of treatment. When a child is uncooperative and these techniques are required, failure to allow these techniques may require discontinuation of care that day and possibly in the future.

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 copayment and any balance not paid for by my insurance is the policy holders/ parents/ Legal Guardians responsibility. The information above is correct to the best of my knowledge. I am aware that I have to inform FHKD **immediately** of any **Insurance Changes at least 48 hours PRIOR** to the day of my appointment. **Same day changes will result in appointment change to a later date.**

Dr. Vissichelli **REQUIRES** appointment confirmation. **If you need to cancel or reschedule your appointment, please notify us at least 24 hours in advance. Appointments cancelled or rescheduled with less than 24 hour notice will incur a \$30 rescheduling fee. We require all patients to be 15 minutes early to appointments for the check-in process. Repeated missed appointments, or a no call/no show for any appointment will result in account inactivation.**

Print Name _____

Signature _____ **Date** _____