

The Hindin Center for Whole Health Dentistry
2 Executive Blvd. Suite 206
Suffern, NY 10901
845-357-1595

Welcome to our Practice!

We strive to make your child's visit pleasant and comfortable. Our goal is to teach your child oral habits which will help maintain a beautiful smile for a lifetime.

Your Child (Please Print)

Child's Name: _____ Nickname: _____

Sex: Male Female D.O.B.: ____ / ____ / ____ Age: _____

Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

School: _____ Grade: _____

Parent/s Responsible for Account & Scheduling appointments:

Name: _____ D.O.B. ____ / ____ / ____

Telephone #: ____ - ____ - ____ Cell: ____ - ____ - ____ Work: ____ - ____ - ____

Employer: _____ Name of Insurance: _____

Social Security#: ____ - ____ - ____ Occupation: _____ Email: _____

I am the parent responsible for making appointments, please contact me via: _____

Name: _____ D.O.B. ____ / ____ / ____

Telephone#: ____ - ____ - ____ Cell: ____ - ____ - ____ Work: ____ - ____ - ____

Employer: _____ Name of Insurance: _____

Social Security#: ____ - ____ - ____ Occupation: _____ Email: _____

I am the parent responsible for making appointments, please contact me via: _____

Parent's Marital Status: Single Married Divorced Widowed Separated

Dental History

How often does your child brush? _____

Floss? _____

Who was your child's previous dentist?

_____ Last Visit? _____

Has your child had previous dental treatment?

Yes No

Any Orthodontic treatment? Yes No

If yes, name of Orthodontist? _____

Is your child having any dental discomfort?

Bleeding gums? Yes No

Is your child's water fluoridated?

Yes No

Does your child take fluoride supplements?

Yes No

Does/Did your child?

Suck thumb/finger Suck bite/lips

chew hard objects Grind teeth

Clench Jaw

Mouth breather? Yes No

Has your child had/have any injuries to the teeth or face? Yes No

Does any member of the family have genetically missing teeth? Yes No if yes, who: _____

History of decay? Yes No

How does your child behave at the pediatrician?

Great Good Fair Poor

How do you feel your child will react towards dental treatment?

Great Good Fair Poor

Does your child have oral habits?

Thumb Finger Pacifier

Is the patient being

Breast fed Bottle Sippy cup

Contents? _____

Medical History

Has your child had any of the following?

Please check any and all that apply.

Visual Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hearing Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Ear Infections	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatoid Arthritis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Blood Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No
Sinus Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tuberculosis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Respiratory Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Rheumatic Heart	<input type="checkbox"/> Yes <input type="checkbox"/> No
Prolonged Bleeding Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Thyroid	<input type="checkbox"/> Yes <input type="checkbox"/> No
Neurological Disorders	<input type="checkbox"/> Yes <input type="checkbox"/> No
Convulsions / Seizures	<input type="checkbox"/> Yes <input type="checkbox"/> No
Heart Murmur	<input type="checkbox"/> Yes <input type="checkbox"/> No
Cardiac Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Liver Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Renal/Kidney Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No
Intestinal Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Muscular Disorder	<input type="checkbox"/> Yes <input type="checkbox"/> No
Coordination Problems	<input type="checkbox"/> Yes <input type="checkbox"/> No
Oral Herpes	<input type="checkbox"/> Yes <input type="checkbox"/> No
Special Needs	<input type="checkbox"/> Yes <input type="checkbox"/> No
Fainting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Tumors	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hepatitis	<input type="checkbox"/> Yes <input type="checkbox"/> No
Learning Disability	<input type="checkbox"/> Yes <input type="checkbox"/> No
ADD/ADHD	<input type="checkbox"/> Yes <input type="checkbox"/> No
Delayed Speech	<input type="checkbox"/> Yes <input type="checkbox"/> No
Major/Minor Surgery	<input type="checkbox"/> Yes <input type="checkbox"/> No
Hospitalizations	<input type="checkbox"/> Yes <input type="checkbox"/> No

Has the patient had any disease/illness not mentioned? Yes No if

yes, _____

As a parent, is there anything you feel we should know about your child?

List of Medications your child is taking: _____

Medication allergies: Yes No if yes, to what:

Allergies: _____

Latex Sensitivity: Yes No

Was your child a full term pregnancy?

Yes No

Was the birth of your child normal?

Yes No

I hereby consent to dental procedures and techniques which the dentist, Dr. Meyer / Hindin in attendance deem necessary for the treatment of the patient. I authorize the dentist to provide any information to the other doctors for purpose of consultation. I understand that prior to any treatment I will be advised about it by the dentist or hygienist, which I may ask questions concerning it; and that I may revoke this consent before treatment is provided. I understand that I may ask for a full recital of any or all risks attendant to the care of the patient.

Parent/ Guardian Signature

D.D.S. Signature

Date: ____ / ____ / ____

Date: ____ / ____ / ____

Policies & Procedures

- **Wait time-** Although we pride ourselves on punctuality; please be patient with us if we are running late. We are working with small children that often require extra attention. Our administrative staff will do their best at keeping you updated on your appointment time.

- **Lateness-** If you think you are going to be late for an appointment please call our office. If you arrive 30 minutes late, at the discretion of the doctor, we may not be able to see you due to our schedule.
- **Broken Appointment-** Available procedure time is VERY limited. With our backlog of patients awaiting treatment, we believe it's not fair to other patients when time scheduled for your appointment goes unused. If we receive less than 48 hours notice of cancellation of an appointment, there will be a charge of \$75.00 to cover the costs of schedule rearrangement. Generally, with advanced notice, we are easily able to fill an appointment time with another patient who has been waiting for this important dental care.

Signature of Parent or Guardian _____ **Date** _____