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

_____ Date:_____/_____/_____

Parent/ Guardian Signature

_____ Date:_____/_____/_____

D.D.S. Signature

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_____