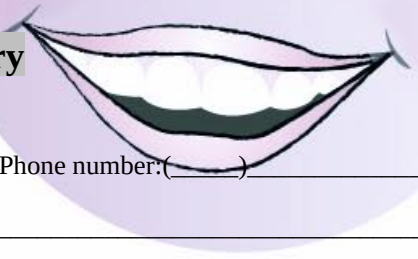
Nia
Pediatric Dentistry
& Family Orthodontics

We are committed to excellence in dentistry and appreciate you taking the time to complete this confidential questionnaire. The better we communicate, the better we can care for you. If you have any questions or need assistance, please ask us we will be more than happy to help.

Patient's Information

Child's name: _____Nickname: _____ Sex: (M) (F)
Birthdate: _____
Purpose of visit: _____Concerns: _____
Name and age of brothers/sisters: _____
Child's Interests: _____
Name of Pet(s): _____
Does your child have any special needs_____
Any phobias? _____
Who may we thank for referring you to us? _____



Dental History

Is this your child's first dental visit? Y N
If no, previous dentist: _____ Phone number:(____)_____
Date of last visit: _____ Were any x-rays taken? Y N
How was his/her experience? _____
Child's attitude towards the dentist or dental care:
_____
Has your child had any injuries to teeth, mouth, or head? Y N
If yes, please describe: _____

Has your child done any of the following (past or present)?
Please circle: thumb/finger-sucking_____ pacifier _____nail biting_____ lip sucking_____
mouth-breathing _____ snoring_____ teeth grinding_____ nursing bottle-feeding_____

Is your water fluoridated? Y N
Does your child take fluoride supplements? Y N
Does your child use fluoridate toothpaste? Y N
How often does your child brush his/her teeth? _____ With adult supervision? Y N
How often does your child floss? _____
How may we help to make this visit a positive experience for your child?
_____

Health History

Child's Pediatrician: _____Phone number: (_____)_____
Last Physical: _____
Is your child under a physician's care now? Y N If yes, reason: _____
Is Immunization up to date? Y N
Is your child taking any medications currently (including over the counter)? Y N
If yes, please list: _____
Is your child allergic to any medication? Y N
If yes, please list: _____
Any history of hospitalization or surgery: Y N
if yes, please explain:_____

Does your child have allergic reaction to: (if yes: please check all that applies)
___ Peanuts/ Tree nuts ___ Soy ___ Latex/ Rubber ___ Pollen/ Dust/ Environmental ___ Anesthetics
___ Eggs ___ Metals ___ Animals ___ Berries ___ Acrylic ___ Milk ___ Wheat/Gluten ___ Dyes/Coloring
Others: _____

Has your child had a history or difficulty with any of the following?

ADHD/ADD Y N	Cardiac Disease/Heart Y N	Hepatitis Y N
Anemia Y N	Cerebral Palsy Y N	Immune Disorder Y N
Allergies Y N	Chemo/Radiation Therapy Y N	Kidney Y N
Arthritis/Joint Disorder Y N	Cystic Fibrosis Y N	Liver Y N
Asthma Y N	Delayed Development Y N	Murmur Y N
Allergies to Medications Y N	Depression/Anxiety Y N	Muscular Disorder Y N
Autism Y N	Diabetes Y N	Premature Birth Y N
Bladder Y N	Down's Syndrome Y N	Rheumatic Fever/Heart Y N
Bleeding Disorder Y N	Earaches/Infections Y N	Speech Disorder Y N
Bone Disorder Y N	Eating Disorder Y N	Sinusitis Y N
Brain Injury Y N	Emotional/School Problems Y N	TMJ Problems Y N
Bruising Y N	Epilepsy/Seizure Y N	Tuberculosis Y N
Cancer/Malignancy Y N	Hearing Impaired Y N	Visual Impaired Y N

Other: _____
If yes, please explain: _____
_____

General Information

Father (full name)_____SSN:_____ Birthdate:_____ Driver's License #:_____
Mother (full name) _____ SSN:_____ Birthdate:_____ Driver's License#:_____
Parent(s) are: Married____ Divorced____ Single____ Widowed____ Partners____
Child lives with: Both Parents _____ Mother _____ Father _____ Other_____
Home Address: _____
Home Phone#:(_____)_____

Father's Employer: _____Cellular Phone:(_____)_____
Business Address:_____ Work Phone:(_____)_____

Mother's Employer: _____Cellular Phone:(_____)_____
Business Address:_____ Work Phone:(_____)_____

E-mail Address:_____
Person financially responsible for child's dental care:_____

Emergency Contact :_____ Relationship _____
Address: _____ Phone:(_____)_____

How would you like us to contact you? Home_____ Work _____Cell_____ E-mail_____

The permission of parent or guardian is necessary for dental treatment of a minor. I give the permission to use such measures as deemed necessary in the dentist's professional judgment to render the best dental treatment for my child. I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform the office of any changes in my child's health status.

SIGNATURE: _____Relationship: _____Date:_____

Insurance Information

Do you have dental insurance coverage for your child? Y N

Father's Insurance Company: _____
Group Number: _____
Address of Father's Insurance Company: _____

Mother's Insurance Company: _____
Group Number_____
Address of Mother's Insurance Company: _____

Financial Agreement

For patients with dental insurance: I hereby authorize the dentist to release any information including diagnosis and records to the third party payer and/or other health care practitioners. I authorize and request my insurance to pay directly to Nia Dentistry LLC. I understand I am financially responsible for any charges not covered by my insurance. I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services. I understand that it is my responsibility to provide accurate and complete insurance information so Nia Dentistry LLC may assist me in filing my claim promptly. I will be required to pay my portion the day of dental treatment. I understand that if my insurance company denies any the claims, I am responsible for the full payment.

For patients without insurances: I understand that payment in full is expected at the time of dental service. When this is not possible, financial arrangements must be made in advance. I realize that the failure to keep this account current may result in the dentist unable to provide additional dental services except for dental emergencies or where there is a prepayment for additional services.

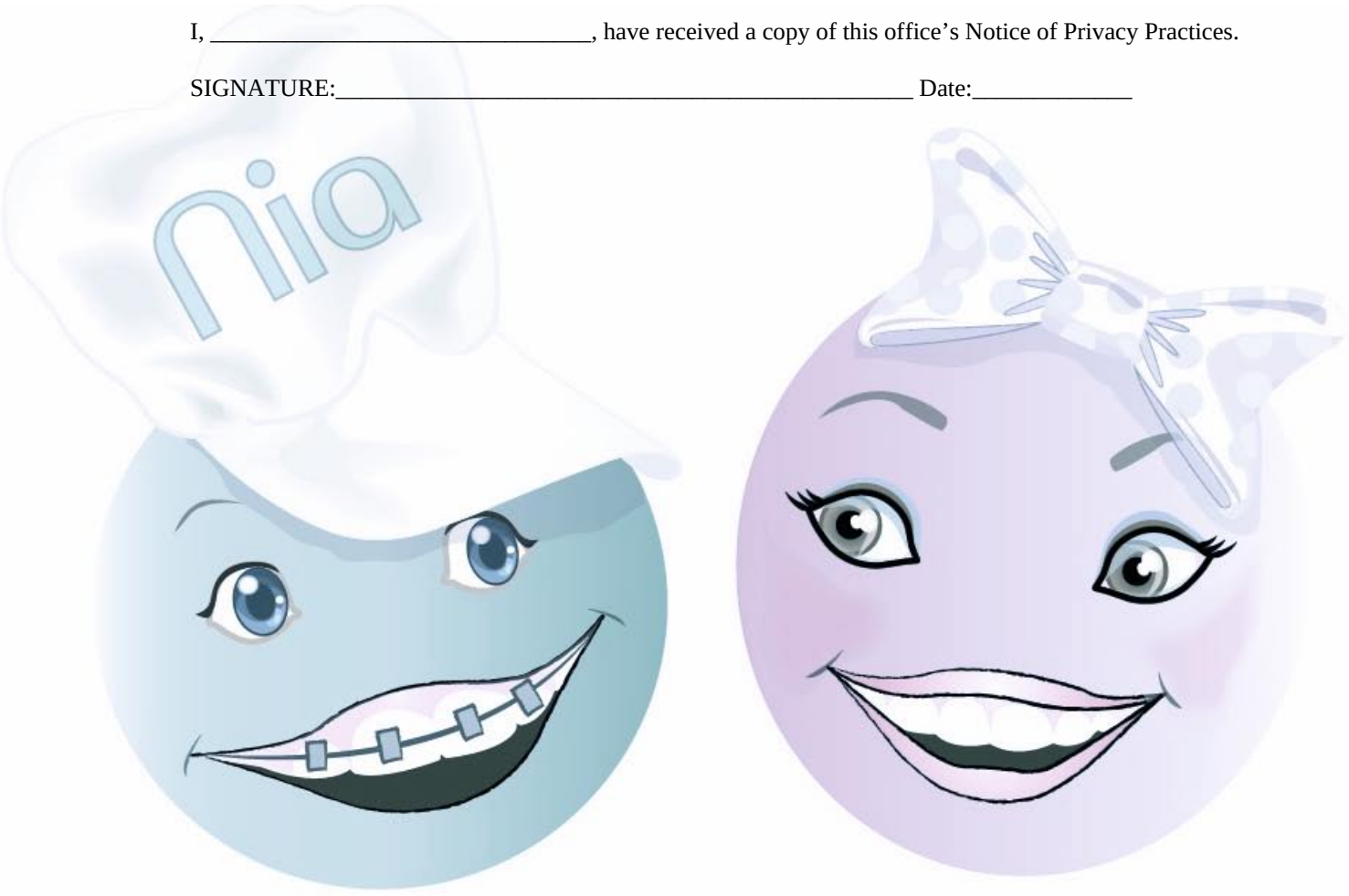
SIGNATURE:_____Relationship:_____Date:_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

SIGNATURE:_____ Date:_____



For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, as required by law, but acknowledgement could not be obtained because:

_____Individual refused to sign
_____Communications barriers prohibited obtaining the acknowledgement
_____An emergency situation prevented us from obtaining acknowledgement
_____Other (Please Explain):_____
_____

Initials_____ Date_____