Valley Smiles
PEDIATRIC DENTISTRY

Valley Smiles Pediatric Dentistry
470 North Franklin Turnpike Suite 106
Ramsey, NJ 07446

Phone: 201-746-4626
Fax: 201-746-4625
info@valleysmilesnj.com

Today's Date:
Patient's Name:
Age: Date of Birth:
Male ☐ Female ☐
Patient's Address: Zip Code:
Names and Ages of Sibling:
Hobbies,Pets,Nickname: School:

Parent Name:
Date of Birth: Social Security #:
Home Address:
Zip Code: Residence Phone:
Email Address: Cell Phone:
Occupation: Company Name: Business Phone:

Parent Name:
Date of Birth: Social Security #:
Home Address:
Zip Code: Residence Phone:
Email Address: Cell Phone:
Occupation: Company Name: Business Phone:

Marital Status of Parents:

PLEASE LET US KNOW WHAT YOUR PREFERRED METHOD OF CONTACT IS:

Text Msg/Cell ☐ Phone ☐ Email ☐

WHOM MAY WE THANK FOR REFERRING YOU?

Name: Address:

DENTAL HISTORY

Is this your child's first trip to the dentist?

In no, please give us the date of the last visit and the name of the dentist.

Please tell us why you are here (routine visit, emergency or other immediate concerns)

Has your child ever been treated for dental injury, toothache, or other emergency?

How has your child behaved during previous dental treatment (if applicable)?

MEDICAL HISTORY

Pediatrician/Physician: Address and Phone:

Please state any medical, emotional, or behavioral condition that your child has or is suspected of having.

Please be specific:

Does your child take any medication? If, so please state name and dosage if know:

Does your child have any allergies to medication? If so, please state:

Does your child have any LATEX allergies? If so, please state:

Does your child have any food or seasonal allergies? If so, please state:

Have you ever been told that your child has a heart murmur? If yes, doe they require antibiotic premedication before a dental visit?

PLEASE CHECK ANY CONDITION THAT APPLIES TO YOUR CHILD:

- ☐ Bleeding Disorders
- ☐ Heart Disease
- ☐ Gastrointestinal
- ☐ Disease Asthma
- ☐ AIDS
- ☐ Seizures
- ☐ Neurologic Disorders
- ☐ Urinary Tract Disorders
- ☐ History of Surgery
- ☐ Diabetes
- ☐ Arthritis
- ☐ Liver Disorders
- ☐ Kidney Disease
- ☐ Sickle Cell Disease
- ☐ Learning Disorders
- ☐ Possibility of Pregnancy
- ☐ Blood Transfusions
- ☐ Premature Birth

Signature of Parent/Guardian: Relationship: Date:

The parent/guardian whose signature appears above is responsible for all fees when services are rendered and consents to treatment as explained to them by the dentist or dental professional.

Authorization for Release of Patient Information:

hereby authorize the above doctor(s) to provide other health care providers with information regarding the above individual's dental care as deemed appropriate. I understand that once released, the above doctor(s) and staff has (have) no responsibility for any future release by the individual receiving this information. **Please Initial**