dr. denis trupkin dr. abby wilentz
dr. george babyak
pediatric dentistry • orthodontics

7400 northwest fifth street
plantation, florida 33317
pediatric dentistry 954-581-7883
orthodontics 954-797-4171
fax 954-581-8043

NEW PATIENT MEDICAL HISTORY

(Please provide your driver's license and insurance card)

Child's Legal Name _____ Nickname _____

Date of Birth _____ Age _____ Sex M ☐ F ☐

Home Address _____

City _____ State _____ Zip _____ Home Phone _____

Mother/Guardian's Cell Phone _____ Father/Guardian's Cell Phone _____

E-mail _____ School _____ Grade _____

DO YOU HAVE INSURANCE THAT MAY COVER ANY PART OF OUR PROFESSIONAL SERVICES? YES ☐ NO ☐

Name of Insured _____ Date of Birth _____ SS # _____

Employer _____ Insurance Company _____

Mother/Guardian's Name _____ Father/Guardian's Name _____

D.O.B. _____ SS # _____ D.O.B. _____ SS # _____

Employer _____ Employer _____

Occupation _____ Occupation _____

Work Phone _____ Work Phone _____

Marital Status: Married ☐ Widowed ☐ Separated ☐ Divorced ☐ Single ☐ Life Partner ☐

In case of emergency, contact: _____ Phone _____

Relationship to patient: _____

List names and ages of brothers and sisters of patient: _____

_____

Whom may we thank for refering your child to us? Not referred how did you hear about us? _____

PATIENT HEALTH RECORD

Does your child have regular medical checkups? Yes ☐ No ☐ Last physical exam _____

Child's Physician: Name _____ Phone _____

Address _____

Does your child have a current medical problem? Yes ☐ No ☐

If Yes, Explain: _____

Is your child currently on any medications? Yes ☐ No ☐ If yes, Medication _____ Dosage _____

Explain _____

What is your child's best method of taking medication? _____

Is your child allergic to: Antibiotics ☐ Novocaine ☐ Pain Reliever ☐ Latex ☐ Food ☐ Other ☐ _____

Explain _____

Has your child ever been hopitalized? Yes ☐ No ☐ When _____

Significant injuries _____

Answering these questions accurately can help us better assess your child's risk of dental disease.

Does your child drink juice, soda, gatorade? ..... Yes ☐ No ☐

Does your child eat chips, crackers, goldfish, pretzels? ..... Yes ☐ No ☐

Do you brush your child's teeth after snacking? ..... Yes ☐ No ☐

Does your child chew any gum / mints containing xylitol? ..... Yes ☐ No ☐

Does your child use any mouth rinse products? ..... Yes ☐ No ☐

Does your child use flouridated toothpaste? ..... Yes ☐ No ☐

Does your child drink flouridated water? ..... Yes ☐ No ☐

Has your child ever had any of the following: Please ☒ and explain below:

☐ Heart trouble	☐ Diabetes	☐ Asthma	☐ Congenital Birth Defects	☐ Seizures
☐ Tuberculosis	☐ Kidney problems	☐ Liver Disease	☐ Headaches	☐ Behavioral problems
☐ Epilepsy	☐ Cleft lip or palate	☐ Speech difficulty	☐ Blood transfusions	☐ Endocrine problems
☐ Bleeding problems	☐ Blood disorder	☐ Lung problems	☐ Blood Dyscrasias	☐ Mental developmental delays
☐ Emotional problems	☐ Jaundice	☐ Cerebral palsy	☐ Cancer / Tumors	☐ Frequent infections
☐ HIV	☐ Hearing problems	☐ Sight problems	☐ Physical Develop. Delays	☐ Autism

☐ Others _____

Explain _____

Has your child ever had any of the following: Please ☒ and explain below:

☐ Thumb Sucking	☐ Finger sucking	☐ Grinding teeth	☐ Lip sucking
☐ Lip biting	☐ Nail biting	☐ Sleeping with mouth open	

Explain _____

Has your child previously been to the dentist? Yes ☐ No ☐ if so,whom? _____

Were there any problems? _____

Has your child ever had any injuries to their teeth? Yes ☐ No ☐

Explain circumstance and when occurred _____

Reason for dental visits _____

Are there any dental problems bothering your child at this time? Yes ☐ No ☐ Explain _____

Additional Comments: _____

I authorize Dr. D.P. Trupkin, Dr. A.T. Wilentz, or any other dentist in the office to treat the above-mentioned patient using restorative or oral surgery techniques as well as patient management techniques that are reasonable and necessary as deemed advisable. I understand that the treatment plan presented, along with the fees outlined, could change depending upon the time elapsed since the examination and the extent of decay. **I also agree to pay all charges NOT covered by insurance. I also acknowledge that I will be responsible for any and all collection fees if this account goes into a delinquent state.**

RELATIONSHIP TO PATIENT _____ SIGNED _____ DATE _____

THANK YOU FOR HELPING US LEARN MORE ABOUT YOUR CHILD.