David I. Ferguson, D.D.S.
177 Gordonhurst Avenue
Upper Montclair, NJ 07043
Phone (973) 744-3181
Fax (973) 337-8648
www.fergusondental.com
frontdesk@fergusondental.com

Date ______________

Child's Name ________________________________ (Last / First / M) Child's Nickname __________

Address ________________________________ (Street / City / Zip)

Phone ______________________ Mother's Work Phone ___________________ Father's Work Phone ________________

Best Number to reach you? _______________ E-Mail Address ________________________________

How would you prefer to be contacted (please circle)? Phone (home, cell, or work) Email Postcard

Sex: M F Child's Birthdate ____ / ____ / ____ Child's Age ________ School ______________________ Grade __________

Who is accompanying your child today? ___________________________

Whom may we thank for referring your child to our office? ______________________________________

Please list any other family members seen by our office ______________________________________

Parent's Marital Status ☐ Married ☐ Domestic Partnership ☐ Single ☐ Separated ☐ Widowed ☐ Divorced

Mother's Name _________________________________ Father's Name _______________________________________

Who will be responsible for paying this account? ______________________________________

Sex: ☐ M ☐ F Date of Birth _____________ Home Phone _________________ Work Phone ____________

Address________________________________ (Street / City / Zip)

Child's Dental History

Reason for visit ______________________________________

Is your child experiencing any pain or discomfort? ______________________________________

Last dental visit? _____________ Previous Dentist ____________________ Previous/Present Orthodontist________________

Has your child ever had any problem associated with any dental treatment? ☐ Yes ☐ No

If yes, please explain ______________________________________

Is there anything you don't like about your child's smile? ☐ Yes ☐ No

If yes, please explain ______________________________________

Is your child's drinking water fluoridated? ☐ Yes ☐ No

Does your child take prescription fluoride vitamins? ☐ Yes ☐ No

How often does your child brush his/her teeth? ____/ per day. Who is responsible for brushing your child's teeth? ______________

What kind of toothbrush does your child use? ☐ Extra Soft ☐ Soft ☐ Medium ☐ Hard ☐ Manual ☐ Electric

How often does your child floss his/her teeth? ___________/Week.

Does your child usually have many cavities? ☐ Yes ☐ No

Does your child gag easily? ☐ Yes ☐ No

Does your child suck his/her thumb or use a pacifier? ☐ Yes ☐ No

PLEASE TURN TO OTHER SIDE

Child's Health History

Physician's Name ________________________________ City ________________________ Phone ____________________________

Has your child been hospitalized during the past two years? ☐Yes ☐No If yes, please explain ______________________________

____

List any medications your child is presently taking ____

List any medications or substances your child has had an adverse or allergic reaction to ______________________________

Has your child ever had an allergic reaction to latex? ☐ Yes ☐ No

Has your child been diagnosed with any social, behavioral or learning disorders? ☐ Yes ☐ No
If yes, please explain ____

Indicate which of the following your child has had or has at present:

☐ Heart Surgery	☐ Diabetes	☐ Cancer _________________	☐ Cold Sores/ Fever Blisters
☐ Congenital Heart Defect	☐ Kidney Problems	☐ Radiation Therapy	☐ Epilepsy/ Seizures
☐ Heart Murmur	☐ Liver Disease	☐ Chemotherapy	☐ Psychiatric Treatment
☐ Mitral Valve Prolapse	☐ Hepatitis	☐ Hemophilia	☐ Handicaps/Disabilities
☐ Rheumatic Fever	☐A ☐B ☐C ☐D ☐E	☐ Sickle Cell Anemia	☐ Hearing Impairment
☐ Artificial Heart Valve	☐ Tuberculosis	☐ HIV+	☐ Asthma

Does your child have any diseases, conditions or problems not listed? ☐ Yes ☐ No
If yes, please explain ____

Insurance

We feel that it is in the best interest of our patients to not participate with any insurance plan. However, we are happy to mximize your benefits and reimbursement for all services. After each visit you will receive a printed claim form to submit to your insurance company for direct reimbursement, and we will assist you in this process.

Consent

I understand the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my child's medical status.
I also authorize the dental staff to perform all necessary dental services that my child may need.

____ ______________________________
Signature of Parent or Guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

I have reviewed the above information and have noted **all** changes in my child's medications and health.

____ ______________________
Signature Date

____ ______________________
Signature Date

____ ______________________

Signature Date