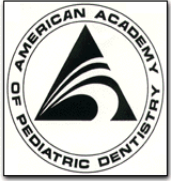


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Bright Healthy Smiles {
HYPERLINK
"http://www.brighthouseysmiles.com" }
First Visit and Adolescent Child (12-18 yrs)

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New York, NY 10065
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WELCOME!

We welcome your child to our practice.
Please take a few minutes to fill out this form as completely as you can.
If you have questions we will be glad to help you.
We look forward to working with you in maintaining your child's dental health.



All questions contained in this questionnaire are strictly confidential
and will become part of your child's dental record.

Is there anything about your child that we should know or consider before working with him or her?

Name (Last, First, MI): FORMCHECKBOX } M { FORMCHECKBOX } F		Today's Date / /	
Nickname	Email	Birthdate / /	Age
Residence		City	State Zip
Home Phone ()		Child's Cell Phone ()	
School		Telephone ()	
School Address		City	State Zip
Siblings	{ FORMCHECKBOX } Yes { FORMCHECKBOX } No	Names/Ages	
Father		Mother	
Marital Status { FORMCHECKBOX } Married { FORMCHECKBOX } Divorced { FORMCHECKBOX } Single Parent { FORMCHECKBOX } Legal Guardian		Marital Status { FORMCHECKBOX } Married { FORMCHECKBOX } Divorced { FORMCHECKBOX } Single Parent { FORMCHECKBOX } Legal Guardian	
Name		Name	
Email		Email	
Employer		Employer	
Work Address		Work Address	
Work Phone	Cell	Work Phone	Cell
Care Giver	Name	Cell Phone	
Whom may we thank for referring you?	Name	Phone	
	Address		
	City	State	Zip

Please continue on page 2

Your Child's Eating Habits:	1. How many times a day does your child snack?
	2. Does your child use vitamins? { FORMCHECKBOX } Yes If Yes, type: { FORMCHECKBOX } No
	3. Does your child drink juice or soda? { FORMCHECKBOX } Yes If Yes, how often: { FORMCHECKBOX } No

CHILD'S DENTAL HEALTH HISTORY

Date of last dental visit.	/ /	Name of previous dentist:	For what reason:
Has child complained about dental problems?	{ FORMCHECKBOX } Yes { FORMCHECKBOX } No	If Yes, Please Explain?	
Any unhappy dental experience?	{ FORMCHECKBOX } Yes { FORMCHECKBOX } No	Describe the experience.	
Any injuries to mouth, teeth, or head?	{ FORMCHECKBOX } Yes { FORMCHECKBOX } No	Describe the injury.	

Are there any mouth habits, such as thumb sucking, nail biting, mouth breathing, use of pacifier (please check the box)

Thumb Sucking	{ FORMCHECKBOX } YES { FORMCHECKBOX } NO	Nail Biting	{ FORMCHECKBOX } YES { FORMCHECKBOX } NO	Mouth Breathing	{ FORMCHECKBOX } YES { FORMCHECKBOX } NO	Use of Pacifier	{ FORMCHECKBOX } YES { FORMCHECKBOX } NO
If yes until what age?		If yes until what age?		If yes until what age?		If yes until what age?	

Have orthodontic appliances ever been worn? { FORMCHECKBOX } Yes { FORMCHECKBOX } No

If yes, explain.

Does your child brush daily?	{ FORMCHECKBOX } Yes { FORMCHECKBOX } No	<i>How often?</i>
Do you assist your child with tooth brushing?	{ FORMCHECKBOX } Yes { FORMCHECKBOX } No	<i>How often?</i>
Is dental floss used?	{ FORMCHECKBOX } Yes { FORMCHECKBOX } No	<i>How often?</i>
Does your child drink fluoridated water?	{ FORMCHECKBOX } Yes { FORMCHECKBOX } No	<i>How often?</i>
Does your child smoke?	{ FORMCHECKBOX } Yes { FORMCHECKBOX } No	<i>How often?</i>
Does your child wear or use an athletic mouthguard?	{ FORMCHECKBOX } Yes { FORMCHECKBOX } No	<i>How often?</i>

CHILD'S GENERAL HEALTH HISTORY

Child's physician or pediatrician

Phone

Address

City

State

Zip

Date of last exam / / Results

Please continue to Page 3

CHILD'S GENERAL HEALTH HISTORY

continued

Is your child under a pediatrician's care now?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name of Pediatrician:	
Is there excessive bleeding when cut?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the child taking any medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What medication?	
Are there emotional or behavioral issues?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>Please Explain</i>	
Has the child ever been hospitalized?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date / /	<i>Please Explain</i>
Has the child ever had surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Date / /	<i>Please Explain</i>
Is the child allergic to any medication?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Which ones?	
Is your child allergic to latex?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Are there other allergies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	What are they?	

Has the child any history of or difficulty with any of the following (*please check the box*): None

<input type="checkbox"/> ADD / ADHD	<input type="checkbox"/> Chronic sinus	<input type="checkbox"/> Eyes	<input type="checkbox"/> Hearing	<input type="checkbox"/> Malignancies	<input type="checkbox"/> Thyroid
<input type="checkbox"/> AIDS – HIV	<input type="checkbox"/> Cleft Lip/Palate	<input type="checkbox"/> Fainting	<input type="checkbox"/> High Fever	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Tonsils / Adenoids
<input type="checkbox"/> Anemia	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Heart	<input type="checkbox"/> Intestinal	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Kidney	<input type="checkbox"/> Skin	<input type="checkbox"/> History of Trauma to the Face
<input type="checkbox"/> Canker Sore	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Headaches	<input type="checkbox"/> Liver	<input type="checkbox"/> Speech Disorder	<input type="checkbox"/>

Please describe any current medical treatment, including drugs, pending surgery, recent injuries, or any other information we should be aware of that has not been discussed.

May we request the release of your child's medical records for our reference?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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I understand that the information that I have provided is correct. It is my responsibility to inform this office of any changes in my child's medical status. I agree that the parent or guardian of the child is responsible for payment.	Print Name Below
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I give my permission for the staff to take dental X-rays of my child.	<input type="checkbox"/> Yes <input type="checkbox"/> No	Please Initial to the right: _____	By signing below this name, I authorize the dental staff to perform all necessary dental services my child may need.
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Relation to the child	<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Other	Signature (parent or guardian)
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IN CASE OF EMERGENCY

Name of local friend or relative	Relation to child	Home Phone	Work or Cell Phone

The Parent or Guardian of the child is responsible for payment of dental services.

Thank you for completing our form!