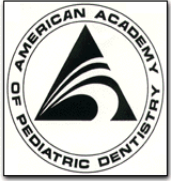


Emanuela F. Corielli, D.D.S.
Amr M. Moursi, D.D.S., Ph.D.

Bright Healthy Smiles
www.brighthealthysmiles.com
First Visit Adolescent Child (12-18 yrs)

1317 3rd Avenue, 10th Floor
New York, NY 10021
Tel (212) 355-7760
Fax (212) 355-7761



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):		<input type="checkbox"/> M <input type="checkbox"/> 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	<input type="checkbox"/> Yes <input type="checkbox"/> No	Names/Ages		
Father		Mother		
Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single Parent <input type="checkbox"/> Legal Guardian		Marital Status <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Single Parent <input type="checkbox"/> 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? <input type="checkbox"/> Yes If Yes, type: <input type="checkbox"/> No
	3. Does your child drink juice or soda? <input type="checkbox"/> Yes If Yes, how often: <input type="checkbox"/> No

CHILD'S DENTAL HEALTH HISTORY

Date of last dental visit.	/ /	Name of previous dentist:	For which reason:
Has child complained about dental problems?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Please Explain?	
Any unhappy dental experience?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe the experience.	
Any injuries to mouth, teeth, or head?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Describe the injury.	
Are there any mouth habits like nail biting or mouth breathing?			
Have orthodontic appliances ever been worn? <input type="checkbox"/> Yes <input type="checkbox"/> No			
<i>If yes, explain.</i>			
Does your child brush daily?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often?	
Do you assist your child with tooth brushing?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often?	
Is dental floss used?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often?	
Does your child drink fluoridated water?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often?	
Does your child smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often?	
Does your child wear or use an athletic mouthguard?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How often?	

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	<i>What medication?</i>	
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? Yes No

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

I give my permission for the staff to take dental X-rays of my child.

Yes 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.

Relation to the child

Mother

Father

Other

Signature (parent or guardian)

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!