37 Professional Parkway
Lockport, New York 14094

Louis A. Surace, DDS

Board Certified Pediatric Dentist

(716) 433-3364

Welcome To Our Office!

We are pleased to welcome you and 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'll be glad to help you. We look forward to working with your child.

Patient Information

Child's Name_____ Nickname_____

Age_____ Date of Birth_____ Sex: ❒ M ❒ F Place of Birth_____

Grade_____ School_____

Child's Address_____ Phone_____

City, State, Zip_____

Notify in case of emergency_____ Home Phone_____ Business Phone_____

Please indicate the FINANCIALLY RESPONSIBLE PERSON:

Name_____ Relationship to Patient_____

THE RESPONSIBILITY OF PAYMENT IS ASSUMED BY THE PARENT/PERSON WHO BRINGS THE CHILD IN FOR THEIR APPOINTMENT.

Mother's Name_____ Birthdate_____ Soc. Sec. No._____

Occupation_____ Employer_____

Business Address_____ Business Phone_____

Home Address (if different from child)_____ Home Phone_____

Father's Name_____ Birthdate_____ Soc. Sec. No._____

Occupation_____ Employer_____

Business Address_____ Business Phone_____

Home Address (if different from child)_____ Home Phone_____

Child lives with (circle one): Both Parents, Mother, Father, Other (name and relationship to child)_____

Who may we thank for referring you to our office?

Name_____

Address_____

Other ways we may contact you?

Cell Phone Number_____

E-Mail Address_____

Insurance Information

Dental Health Insurance ❒ Y ❒ N

If yes, please specify carrier

(Primary)_____

(Secondary)_____

Dental Primary Insurance

Dental Insurance Company_____

Subscriber's Name_____ Relation to Child_____

Last Name First Name Initial

Subscriber's Birthdate_____Subscribers Soc. Sec. No._____

Address (if different from child)_____ Home Phone_____

City_____ State_____ Zip_____

Employer Name_____

Business Address_____ Business Phone_____

Group #_____ Subscriber ID#_____

Is child covered by additional insurance? ❒ Y ❒ N

Dental Secondary Insurance

Dental Insurance Company_____

Subscriber's Name_____ Relation to Child_____

Last Name First Name Initial

Subscriber's Birthdate_____Subscribers Soc. Sec. No._____

Address (if different from child)_____ Home Phone_____

City_____ State_____ Zip_____

Employer Name_____

Business Address_____ Business Phone_____

Group #_____ Subscriber ID#_____

Insurance Authorization

I authorize the insurance company indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize use of this signature on all insurance submissions.

I authorized the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid insurance.

Signature_____ Date_____

Copayments (out of pocket expenses) are expected to be paid at the time of service.

For your convenience, we gladly accept payment in the form of cash, check, MasterCard/Visa/American Express

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Medical History

Child's Name_____ Child's Physician's Name_____

Physician's Address_____Physician's Phone_____Date of last visit_____

Is your child in good health? ❒ Yes ❒ No

Are your child's immunization up to date? ❒ Yes ❒ No

Does your child have regular medical examinations? ❒ Yes ❒ No

Is your child currently under a physicians care? ❒ Yes ❒ No If yes, please describe_____

Is your child taking any medication at the present time? ❒ Yes ❒ No If yes, please specify_____

Has your child had any serious illnesses or operations? ❒ Yes ❒ No If yes, please describe_____

Has your child or any family member ever had
Any adverse reactions to general anesthesia? ❒ Yes ❒ No If yes, please describe_____

Has your child ever had an unfavorable reaction to a drug or medicine? ❒ Yes ❒ No

If yes, please describe_____

Does your child need premedication for dental care due to an existing heart condition? ❒ Yes ❒ No

Has your child ever been diagnosed as having any of the following conditions? (PLEASE CHECK YES OR NO)

YES	NO		YES	NO		YES	NO		YES	NO	
❒	❒	AIDS	❒	❒	Allergies to medication	❒	❒	Anemia	❒	❒	Asthma
❒	❒	Autism	❒	❒	Bladder conditions	❒	❒	Bleeding problem	❒	❒	Blood transfusions
❒	❒	Birth Defects	❒	❒	Bone or Joint problems	❒	❒	Brain injury	❒	❒	Bruising frequently
❒	❒	Cancer or Malignancies	❒	❒	Cerebral Palsy	❒	❒	Child Abuse	❒	❒	Cough (persistent)
❒	❒	Chronic ear infections	❒	❒	Cleft Lip/Palate	❒	❒	Convulsions/Seizures	❒	❒	Developmental problems
❒	❒	Diabetes	❒	❒	Drug or Alcohol Problem	❒	❒	Emotional disturbance	❒	❒	Epilepsy
❒	❒	Eye Problems	❒	❒	Excessive gagging	❒	❒	Fainting or dizziness	❒	❒	Food allergies
❒	❒	Frequent infections	❒	❒	Gastrointestinal Disease	❒	❒	Headaches	❒	❒	Hearing/Speech problems
❒	❒	Heart murmur/heart defect	❒	❒	Hemophilia	❒	❒	Hepatitis	❒	❒	Hyperactivity
❒	❒	Kidney Disease	❒	❒	Leukemia	❒	❒	Liver Disease	❒	❒	Lung Disease
❒	❒	Mental Retardation	❒	❒	Nutritional/Eating Disorders	❒	❒	Oral ulcers	❒	❒	Orthopedic problems
❒	❒	Pneumonia	❒	❒	Premature Birth	❒	❒	Rheumatic Fever/Scarlet Fever	❒	❒	Scoliosis
❒	❒	Sickle Cell Anemia	❒	❒	Sinus Problems	❒	❒	Sore throat (Frequent)	❒	❒	Spina Bifida
❒	❒	Syndrome	❒	❒	Tuberculosis	❒	❒	Chronic Adenoid/Tonsil infection			
❒	❒	Tubes/Shunts/Prosthesis	❒	❒	Material allergies (latex, wool, metal, chemicals)						

Please describe any conditions checked above, and list any other medical information we should be aware of that has not been covered.

_____

_____

Dental History

Is this your child's first dental visit? ❒ Yes ❒ No

What is the reason for your child's visit to our office today?_____

Former Dentist_____ Address_____ Phone_____

Date of last dental care_____ Date of last x-rays_____

Does an adult assist with brushing? ❒ Yes ❒ No Flossing? ❒ Yes ❒ No

How often does your child brush?_____ Floss?_____

Does your child snack frequently? ❒ Yes ❒ No

Does your child experience pain of discomfort in the jaw joint? ❒ Yes ❒ No

Has your child ever experienced teeth, mouth, jaw, chin or head injury? ❒ Yes ❒ No

If yes please describe_____

Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure? ❒ Yes ❒ No

If yes please describe_____

Other information about your child's dental health or previous treatment_____

Does your child have any of the following habits? (circle any that apply)

bottle at bedtime, pacifier or thumb sucking, finger or lip sucking, teeth grinding, mouth breathing, tongue thrust, tobacco use

What fluoride sources does your child receive? (circle any that apply) prescription, vitamins, water supply, tablets/drops, toothpaste, rinse/gel

How has your child reacted to previous dental visits? ❒ Positive ❒ Negative

How do you expect your child to react to today's visit? ❒ good ❒ fair ❒ poor ❒ don't know

Please describe your child's personality:_____

Authorization

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be held in the strictest confidence, and used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist. I also authorize the dental staff to perform the necessary dental services for my child.

Signature (Parent or Legal Guardian)_____ Date_____
circle one

For Office Use Only

Medical and Dental History Summary:_____

_____

_____

_____

_____

This questionnaire has been reviewed by:

Signature_____ Title_____ Date_____