STEPHEN B.KORSON, DDS

PEDIATRIC AND ADOLESCENT DENTISTRY - Specialty Permit # 2643
115 Kent Place Boulevard, Summit, New Jersey 07901

NEW PATIENT QUESTIONAIRE AND HEALTH HISTORY

Please fill in the registration information and child's personal heath history. This information is an important aid in making a thorough evaluation of your child's dental health.

DATE:_____

CHILD'S NAME_____FAMILY NAME_____NICKNAME_____

DATE OF BIRTH_____CHILD'S AGE_____SCHOOL & GRADE_____

STREET ADDRESS_____FAMILY E-MAIL _____

CITY_____STATE_____ZIP_____

HOME TEL. #_____-_____-_____CELL PHONE:_____-_____-_____

FATHER'S NAME_____MOTHER'S NAME_____

[ ]MARRIED [ ] SEPARATED [ ] DIVORCED [ ] WIDOWED [ ] SINGLE

FATHER'S OCCUPATION_____EMPLOYER_____

SS#_____-_____-_____BUS. TEL. #_____-_____-_____

DENTAL INSURANCE CARRIER_____GROUP #_____

MOTHER'S OCCUPATION_____EMPLOYER_____

SS#_____-_____-_____BUS. TEL. #_____-_____-_____

DENTAL INSURANCE CARRIER_____GROUP #_____

CHILD'S HOBBIES (PETS, FAVORITE TV SHOWS, ETC.)_____

_____

OTHER CHILDREN IN THE FAMILY (NAMES AND AGES):

PATIENTS OF DR. KORSON_____

NOT PATIENTS_____

CHILD'S PHYSICIAN_____CITY_____

FAMILY'S DENTIST_____CITY_____

HOW DID YOU HEAR OF DR. KORSON? _____

PLEASE CHECK APPROPRIATE BOXES: [ ] FRIEND [ ] VERIZON YELLOW BOOK [ ] LOCAL YELLOW BOOK
[ ] PEDIATRICIAN [ ] DENTIST [ ] SIGN [ ] NURSERY SCHOOL [ ] AD [ ] INTERNET [ ] OTHER

WHOM MAY WE THANK FOR REFERRING YOU? _____

WHAT IS THE MAIN REASON FOR THIS VISIT? (1ST EXAM, CAVITIES OR TOOTHACHE, CRACKED TOOTH, BRACES OR INVISALIGN AND ORTHODONTIC ISSUES, 2ND OPINION, ETC.)

_____

_____

OVER

	YES	NO
DOES YOUR CHILD HAVE A HEALTH PROBLEM?	[ ]	[ ]
DOES YOUR CHILD TAKE ANY MEDICINE REGULARLY?	[ ]	[ ]
DOES YOUR CHILD TAKE FLUORIDE VITAMINS?	[ ]	[ ]
HAS YOUR CHILD HAD ANY UNFAVORABLE REACTIONS TO ANY MEDICINES OR DRUGS?	[ ]	[ ]
HAS YOUR CHILD EVER BEEN HOSPITALIZED OR HAD SURGERY?	[ ]	[ ]
HAS YOUR CHILD HAD ANY EMOTIONAL PROBLEMS OR PSYCHOLOGICAL DISORDERS?	[ ]	[ ]
DOES YOUR CHILD SUCK HIS/HER THUMB, FINGERS, OR PACIFIER?	[ ]	[ ]
HAS YOUR CHILD EXPERIENCED ANY UNFAVORABLE REACTION FROM PREVIOUS DENTAL OR MEDICAL TREATMENT?	[ ]	[ ]
HAS YOUR CHILD'S TEETH EVER BEEN INJURED IN A FALL OR ACCIDENT?	[ ]	[ ]
DOES YOUR CHILD REQUIRE ANTIBIOTIC PRE-MEDICATION FOR DENTAL TREATMENT?	[ ]	[ ]
HAS YOUR CHILD HAD ANY RECENT DENTAL X-RAYS OR MODELS?	[ ]	[ ]

PLEASE EXPLAIN ANY YES ANSWERS? _____

_____

_____

_____

AS YOUR CHILD HAD ANY HISTORY OF THE FOLLOWING CONDITIONS? PLEASE PLACE A ✓ NEXT TO THOSE WHICH APPLY.

[ ] HEART TROUBLE	[ ] COGNITIVE DISABILITY	[ ] VISUAL IMPAIRMENT
[ ] RHEUMATIC FEVER	[ ] BLEEDING DISORDER	[ ] SPEECH PROBLEMS
[ ] ASTHMA	[ ] CONVULSIVE DISORDER	[ ] TUBERCULOSIS
[ ] ANEMIA	[ ] BRAIN INJURY	[ ] FAINTING SPELLS
[ ] KIDNEY DISEASE	[ ] CEREBRAL PALSY	[ ] NERVOUS PROBLEMS
[ ] HEPATITIS	[ ] CLEFT LIP OR PALATE	[ ] AUTISTIC SPECTRUM
[ ] LIVER DISEASE	[ ] LEARNING DISABILITY	[ ] STOMACH PROBLEMS
[ ] DIABETES	[ ] AUTO-IMMUNE DISEASES	[ ] EATING DISORDERS
[ ] HEART MURMUR	[ ] HEARING LOSS	[ ] ANY UNUSUAL CONDITION

EXPLAINATIONS: _____

_____

_____

CONSENT FOR TREATMENT OF A MINOR

THE UNDERSIGNED HEREBY AUTHORIZES DR. KORSON AND APPROPIATE STAFF TO PERFORM THE EXAMINATON AND AFTER EXPLAINATION, THE NECESSARY DENTAL SERVICES, USING METHODS APPROPRIATE FOR THE CARE OF THE ABOVE NAMED CHILD.

SIGNED _____ *RELATIONSHIP TO CHILD* _____