



**PEDIATRIC DENTISTRY**  
AND  
**ORTHODONTICS FOR ALL AGES**

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Phone (315) 637-6961  
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**Patient Information**

Last name _____	First name _____
Address _____	City _____ State _____
Zip code _____	Home phone _____ Work phone _____
Cell phone _____	DOB _____ SS# _____
E-mail Address _____	Marital status _____
Place of employment _____	Occupation _____
Primary Dental Ins. _____	Subscriber# _____
Ins. Address _____	
Ins. Phone number _____	Group # _____
Insured's name _____	SS# _____
DOB _____	Relationship to patient _____

**Where would you like your appointment confirmed?**  
( ) home phone ( ) work phone ( ) cell phone

Has a member of your family been treated in our office? \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_

**Primary Reason For This Dental Appointment**

\_\_\_ Examination \_\_\_ Emergency \_\_\_ Consultation

**Dental History**

- Do you have a specific dental problem? **Yes/No** If yes, describe \_\_\_\_\_
- Do you have dental examinations on a routine basis? **Yes/No**
- Do you think you have active decay or gum disease? **Yes/No**
- Do your gums ever bleed? **Yes/No** If yes, describe \_\_\_\_\_
- Do you brush an floss on a routine basis? **Yes/No**
- Do you feel nervous about having dental treatment? **Yes/No** If yes, explain \_\_\_\_\_
- Have you ever had a bad experience in a dental office? **Yes/No** If yes, explain \_\_\_\_\_
- Name and address of previous dentist \_\_\_\_\_
- Do you grind your teeth? **Yes/No** If yes, explain \_\_\_\_\_
- Do you have TMJ Disorder? **Yes/No**

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11. Are you currently under the care of a physician? **Yes/No** If yes, explain \_\_\_\_\_
12. Name of primary care physician. \_\_\_\_\_  
Name of specialist \_\_\_\_\_
13. Are you currently taking any medications? **Yes/No** If yes, please list. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
14. Do you have a history of a heart murmur? **Yes/No** If yes, do you require medication prior to dental procedures? **Yes/No**
15. Do you have a history of prolonged bleeding? **Yes/No** If yes, please explain \_\_\_\_\_  
\_\_\_\_\_
16. Have you ever had surgery or been hospitalized? **Yes/No** If yes, please explain \_\_\_\_\_  
\_\_\_\_\_
17. Please list any allergies to antibiotics, prescription medications or over the counter medications:  
\_\_\_\_\_  
\_\_\_\_\_
18. Please list any other allergies such as Latex, pollen, etc. \_\_\_\_\_  
\_\_\_\_\_
19. Do you require pre-medication prior to dental visits? **Yes/No** If yes, why? \_\_\_\_\_  
\_\_\_\_\_
20. Do you have Osteopenia or Osteoporosis? **Yes/No**  
If yes, which one and please list any medications you are taking for it. \_\_\_\_\_  
\_\_\_\_\_

**Please circle if you have any of the following:**

ADD/ADHD	Celiac Disease	Excessive Thirst	Hypoglycemia	Scarlet Fever
Acid Reflux	Cerebral Palsy	Fainting/Dizziness	Kidney Trouble	Sinus Trouble
Anemia	Convulsions	Fever Blisters	Lactose Intolerant	Shunt/Stent
Autism	Chemotherapy	Frequent Cough	Liver Disease	Shortness of Breath
Artificial Joints	Chest Pain	Heart Murmur	Lung Disease	Stroke
Arthritis	Diabetes	Heart Trouble	Pain in Jaw Joints	Swelling of Feet/Ankles/Hands
Artificial Heart Valve	Disabilities	Hemophilia	Pacemaker	TIA
Behavior Problems	Down Syndrome	Hepatitis A,B, or C	Parathyroid Disease	Tuberculosis
Bi-Polar Disorder	Drug Addiction	Herpes	Psychiatric Care	Thyroid Disease
Blood Transfusions	Epilepsy	High Blood Pressure	Rheumatic Fever	Ulcer
Cancer	Emphysema	HIV/AIDS	Rheumatism	Venereal Disease

Please list any conditions you have that are not mentioned above.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_ Phone \_\_\_\_\_  
Address \_\_\_\_\_

**Account Information**

I am aware that payment is expected at the time of service and agree to pay Pediatric Dentistry & Orthodontics for All Ages in full, at that time services are rendered, unless a prior arrangement has been worked out with our Business Staff.

\_\_\_\_\_  
(Signature of patient, if a minor than signature of parent or guardian of patient)

Date \_\_\_\_\_

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