Dr. John Gennantonio
Dr. Katie Lubitz Stewart
Diplomat, American Board of Pediatric Dentistry

sea of smiles
pediatric dentistry

Patient's Physician ______________________ Phone #______________

Physician's address ______________________

1. Is your child under the care of a physician for any illness or health problems? ❑ Yes ❑ No
2. Does your child have, or ever had, any of the following health conditions?

Condition	Yes	No
Abnormal Bleeding problems	❑ Yes	❑ No
AIDS or AIDS Related Complex	❑ Yes	❑ No
Allergies	❑ Yes	❑ No
Anemia	❑ Yes	❑ No
Asthma or Other Respiratory problems	❑ Yes	❑ No
Arthritis	❑ Yes	❑ No
Artificial Limb or Implant	❑ Yes	❑ No
Autism	❑ Yes	❑ No
Bladder Disorder	❑ Yes	❑ No
Blood Disorder	❑ Yes	❑ No
Blood Transfusion	❑ Yes	❑ No
Cancer	❑ Yes	❑ No
Cerebral Palsy	❑ Yes	❑ No
Convulsions or Seizures	❑ Yes	❑ No
Developmental Disability	❑ Yes	❑ No
Diabetes	❑ Yes	❑ No
Down Syndrome	❑ Yes	❑ No
Ear, Nose or Throat Problems	❑ Yes	❑ No
Emotional Problems	❑ Yes	❑ No
Fainting	❑ Yes	❑ No
Hearing Problems	❑ Yes	❑ No
Heart Murmur	❑ Yes	❑ No
Heart Problems	❑ Yes	❑ No
Hepatitis, jaundice or Liver Problems	❑ Yes	❑ No
High Blood Pressure	❑ Yes	❑ No
Hyperactivity	❑ Yes	❑ No
Kidney Disorders	❑ Yes	❑ No
Learning Disability	❑ Yes	❑ No
Premature Delivery	❑ Yes	❑ No
Pregnancy	❑ Yes	❑ No
Radiation Therapy	❑ Yes	❑ No
Rheumatic Fever or Heart Diseases	❑ Yes	❑ No
Sensory Issues	❑ Yes	❑ No
Tuberculosis	❑ Yes	❑ No
Thyroidism - Hyper or Hypo	❑ Yes	❑ No

Please explain "yes" answers:

____

____

____

3. Does your child have any diseases, syndrome or a handicap not listed above? ❑ Yes ❑ No
   If yes, describe ______________________
4. Is your child taking any over the counter drugs or prescription medications? ❑ Yes ❑ No
   If yes, name of medication(s) ______________________
5. Has your child had any allergies or any adverse side affect to any drugs or medications, including local anesthetic, penicillin, codeine, fluoride, etc.? ❑ Yes ❑ No
   If yes, name of medication(s) ______________________
6. Has your child ever been hospitalized? ❑ Yes ❑ No
7. Has your child ever had any surgeries? ❑ Yes ❑ No
8. Has your child or any relative had a problem with general anesthesia? ❑ Yes ❑ No
9. Does your child use fluoridated water at home? ❑ Yes ❑ No Cincinnati water? ❑ Yes ❑ No
   Fluoride supplements? ❑ Yes ❑ No Fluoride rinses? ❑ Yes ❑ No
10. Is this your child's first visit to the dentist? ❑ Yes ❑ No
11. Has your child complained about dental problems? ❑ Yes ❑ No
12. When was your child's last trip to the dentist? ______________________
    Name of previous dentist ______________________
13. Has your child had an unhappy dental experience? ❑ Yes ❑ No
14. Who brushes your child's teeth? ______________ How Often?__________
15. Is your child going to sleep with a bottle? ❑ Yes ❑ No
    What does the bottle contains: ❑ Water ❑ Milk ❑ Formula ❑ Juice ❑ Other
16. Is your child presently breast feeding? ❑ Yes ❑ No
17. Any oral habits (thumb sucking, pacifier, nail biting, etc.)? ❑ Yes ❑ No
18. Any history of injuries to mouth, teeth, or head? ❑ Yes ❑ No
    If Yes, describe injury ______________________

The statements on both sides of this form are to the best of my knowledge true and correct. I agree to report any health changes to the Doctor prior to any treatment. I hereby authorize the Doctor and staff to provide examination, x-rays and procedures to diagnose oral and dental disease and to provide necessary dental services.

Patient's Name ______________________ Date ______________

Signature of Parent or Legal Guardian ______________________

Doctor Notes: ______________________

____

OVER ⇨

Dr. John Gennantonio
Dr. Katie Lubitz Stewart
Diplomat, American Board of Pediatric Dentistry

sea of smiles
pediatric dentistry

Patient Name ______________________________ Male or Female Date of Birth ______________

Address ______________________________ City ______________________________

State ______________ Zip______________ Home Phone ______________

Child's School ______________________________ Sibling Names ______________________________

Hobbies ____

Mother's Name ______________________________ Mother's Cell Phone ______________________________

Mother's S.S. No. ______________ Mother's D.O.B. ________ Employed By ______________

Father's Name ______________________________ Father's Cell Phone ______________________________

Father's S.S. No. ______________ Father's D.O.B. ________ Employed By ______________

Email Address: ____

Who may we thank for referring you? ______________________________

PRIMARY DENTAL INSURANCE

Name of Insured ______________________________ Relationship to Patient ______________

Insured's Date of Birth ______________ Social Security Number ______________

Name of Employer ______________________________ Work Phone ______________

Insurance Company ______________________________ Member ID ______________ Group #______________

Claims Address ______________________________ City ______________ State ________ Zip ________

Insurance Company Phone Number ______________________________

SECONDARY DENTAL INSURANCE

Name of Insured ______________________________ Relationship to Patient ______________

Insured's Date of Birth ______________ Social Security Number ______________

Name of Employer ______________________________ Work Phone ______________

Insurance Company ______________________________ Member ID ______________ Group #______________

Claims Address ______________________________ City ______________ State ________ Zip ________

Insurance Company Phone Number ______________________________

In case of emergency please list the name, phone number and relationship to the patient not living at home: __________

____

Because your child is a minor it becomes necessary that a signed permission be obtained from a parent or guardian before any/and all necessary dental services be rendered. Authorization is hereby granted for Dr. John Gennantonio and Dr. Kathryn Stewart to provide dental care for their child. Furthermore, I acknowledge receipt of the office policy as to charges and payments and agree to comply. I will be financially responsible for the charges incurred for the dental treatment of this child.

Signature of parent or guardian ______________________________ **Date** ______________________________

OVER ⇨