Pediatric Dentistry
Rainbow Kids Dental

S. LEE, D.M.D.
NJ SPECIALTY NO. 4007
3900 PARK AVENUE SUITE 105
EDISON, NJ 08820
(732) 452-0100

Date:_____

Child's Name:_____ Nickname: _____

Mailing Address: _____ City:_____ State:_____ Zip: _____

Sex: M / F Age:_____ Birth date:____/_____/_____ SS#:_____
(Circle One)

Name of Responsible Party:_____ Relationship to Child:_____

Mailing Address: _____ City:_____ State:_____ Zip: _____

Sex: M / F Age:_____ Birth date:____/____/_____ Single Married Widow Separated Divorced SS#: _____
(Circle One) (Circle One)

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Email Address:_____Occupation:_____

Employer: _____

Employer Address: _____ City: _____ State:_____ Zip: _____

Family Member Information

Please list the names of your spouse and children.	Is person a patient?		Sex		Age	Date of birth
	Yes	No	M	F		

Please list the names of your spouse and children.	Is person a patient?		Sex		Age	Date of birth
	Yes	No	M	F		

Who may we thank for referring you to our office? _____

INSURANCE INFORMATION

Policy Holders Name:_____ Relationship to Patient:_____ SS#:_____ DOB____/____/ ____

Name of Employer: _____ Employer Address:_____ State: _____

Insurance Co._____ Group #:_____ Address: _____

Secondary Insurance Information

Policy Holders Name:_____ Relationship to Patient:_____ SS#:_____ DOB____/____/ ____

Name of Employer: _____ Employer Address:_____ State: _____

Insurance Co._____ Group #:_____ Address: _____

I certify that all the information (including medical, personal, and insurance records) is true and complete. I give my full permission to Rainbow Kids Dental to check and verify my credit and/or employment history. I further understand that Rainbow Kids Dental will assist me in filing my child's claims, but the insurance coverage I have for dental services can vary and will depend on my insurance plan.

I understand that I am responsible for all fees and services. Since our doctors often provide continuing education to other doctors, I give my permission to use my child's photos for educational purposes.

I give permission, in my absence, to provide examinations, dental cleanings and necessary x-rays as part of routine care for this patient.

We require 48 hours advance notice if you are unable to keep your appointment. Failure to do so could result in a charge. Finance charges will be assessed on any account that is 60 days or more past due at the rate of 5% per month. Thank you for your cooperation.

Parent or Guardian: _____

(please complete both side)

Medical History

Physician's name _____ Address _____ Phone _____

Date of Last visit _____ Results _____

Does your child currently have/previously had any of the following health problems?

Yes	No		Yes	No	
☐	☐	Allergies (Food, Dust, Drug, Unknown) If yes, Please list_____	☐	☐	Any Current/Recent Injuries
☐	☐	Rheumatic Fever / Rheumatic Heart Disease	☐	☐	Childhood Illness
☐	☐	Congenital Heart Disease or Hearth Murmur	☐	☐	Blood Transfusion
		If yes, Premed Needed? _____	☐	☐	Any Prolonged Bleeding/Bruises Easily
		Name of Pharmacy: _____	☐	☐	Kidney or Bladder Problems
		Pharmacy Phone Number: _____	☐	☐	Tuberculosis or Pneumonia
☐	☐	Glandular or Hormonal Problems	☐	☐	Liver Problems, Jaundice or Hepatitis
☐	☐	Diabetes/Blood Sugar Problems	☐	☐	Accidents or Severe Infections
☐	☐	Arthritis or Rheumatism (painful, swollen joints)	☐	☐	Psychological or Emotional Problems
☐	☐	Convulsions, Seizures, Fainting or Epilepsy	☐	☐	Any Pending/Recent Surgery
☐	☐	Anemia or Blood Disorders	☐	☐	Speech, Learning, or Hearing Disorders
☐	☐	High/Low Blood Pressure	☐	☐	ADD/ADHD
☐	☐	Asthma or Hay Fever (Please Indicate) If yes, please list any current medications: _____	☐	☐	Autism

Are your child's Immunizations Current? _____

Please explain any other medical concerns/Current Medication(s): _____

Dental History

Date of Last Dental Visit _____ By Dr. _____

Do you have any Current Records (including x-rays) from another practice? ☐Yes ☐No

Has your child complained about any dental problems? _____

Any injuries or surgeries to mouth, teeth, head? ☐Yes ☐No If yes, please describe: _____

_____

Does your child still take the bottle or sippy cup? _____

Does your child brush daily? ☐Yes ☐No How Often? _____

Is Dental Floss used? ☐Yes ☐No

Please check each box if your child has any of the following mouth habits

☐Thumb Sucking ☐Mouth Breathing ☐Pacifier ☐Nail Biting ☐Finger Sucking ☐Grinding ☐Other_____

How does your child receive Fluoride?

☐Water Supply ☐Dentist ☐Toothpaste ☐Vitamins ☐Tablets ☐None

☐Other: _____

Child's Attitude Towards Dentistry: _____

Reason for Today's Visit/Chief Concerns: _____

Authorizations

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child.

_____

(Signature of Parent/Guardian) (Date)

I certify that my minor/child is covered by insurance with _____

(Name of Insurance Company)

And assign directly to Rainbow Kids Dental (Dr.Lee) all insurance benefits, if any, otherwise payable to me for services rendered. I Understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submission, whether manual or electronic.

_____

(Signature of Parent/Guardian) (Date)