Shining Stars Kids Dentistry PC
General Dentistry for Children
Lawrence Musarra DDS, PhD

Patient Information (Please print in ink)

First Name: _____ MI: ____ Last Name _____ DOB: _____

Street: _____ City: _____ State: ____ Zip: _____

Child School: _____ Grade: _____Gender: F__M__ Race/Ethnicity (Optional) _____

Guardian Information (Please print in ink)

Parent/Guardian Name: _____ Parent/Guardian Email: _____

*Parent/Guardian Social Security #: _____ *Parent/Guardian DOB: _____ Phone: _____

Dental Insurance Information: (Please print in ink)

Insurance Company:_____ Primary Insures Name:_____ DOB:_____

Insurance Policy Number:_____ Insurance Group Number:_____

Whom may we thank for referring you/how did you hear about us?_____

Patient Health History (Please answer all questions)

Heart Trouble	Yes	No	Anemia	Yes	No	Kidney or Liver Disease	Yes	No
Tuberculosis	Yes	No	Pregnant	Yes	No	Diabetes	Yes	No
Hepatitis	Yes	No	Epilepsy	Yes	No	Bleeding/Clotting Problems	Yes	No
HIV/AIDS	Yes	No	Allergies	Yes	No	Disabilities/Special Needs	Yes	No
Asthma/Breathing Problems	Yes	No	Use of Diet Pills/Diet Aids (including Phen-Fen)	Yes	No	Artificial/Prosthetic Joints, Plates or Pins	Yes	No
Autism	Yes	No	Rheumatic Fever	Yes	No	Heart Murmur	Yes	No
Sickle Cell Anemia	Yes	No	ADHD/ADD	Yes	No	Alcohol/Drug Abuse	Yes	No
Fainting/Seizures	Yes	No	Speech/Hearing Problems	Yes	No	Birth Defects	Yes	No
Tobacco Use	Yes	No	Has the patient had surgery?	Yes	No	Other?		

*****ANSWER ALL BELOW:*****

If you answered "yes" to any of the above, please explain: _____

_____

_____

Does the patient have any other health problems? If yes, Please explain: _____

Is the patient taking any medications at this time (including over-the-counter medications such as aspirin)?
Yes __ No __ If "Yes", what type: _____

Is the patient allergic to medications? If "yes", what? _____
Is that patient allergic to anything else? If "yes', what? _____

Does the patient have any dental problems/concerns? If yes, please explain_____

***Closest Relative not living with patient:_____ Relationship:_____ Phone:_____

Other family members seen in the office:_____

Patient's Pediatrician/Family Physician:_____ Phone:_____

I certify that I have read and understand the above. I acknowledge that my questions, if any, have been answered to my satisfaction. I will not hold the dentist, or any other member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form. I consent for the examination, teeth cleaning, application of topical fluoride, and any necessary x-rays and clinical photographs, and any necessary sealants.

Dentist Signature:_____

Parent/Guardian signature:_____ **Date:**_____