Joseph A. DiBenedetto, D.M.D.
3211 Sunset Avenue
Ocean, NJ 07712
Phone: 732-988-7272

Tell Us About Your Child

Child's Name: _____ Date:_____
Last First MI

☐ Male ☐ Female Birth Date:_____ Nickname_____

Phone (Home): _____ Father Work #: _____ Father Cell #:_____

Mother Work #: _____ Mother Cell #:_____

Child resides with: Mother and Father_____ Mother_____ Father_____ Other_____

Address: _____

_____

Emergency contact (Name)_____(Phone)_____

Health Information

Date of Last Dental Visit: _____ Reason for this visit:_____

Has your child ever had any of the following? Please check those that apply:

☐ Allergies (List)
_____
☐ Anemia
☐ Asthma
☐ Blood Disease
☐ Cancer
☐ **Congenial Heart Defect**
☐ Diabetes
☐ Epilepsy/Seizures
☐ Excessive Bleeding
☐ Fainting/ Dizziness
☐ Growths
☐ Handicaps/Disability
☐ Head Injuries
☐ Hearing Impairment

☐ Heart Disease/Surg
☐ Heart Murmur
☐ Hepatitis
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Nervous Disorders
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Tuberculosis
☐ Tumors
☐ Other (please list)
_____
_____

☐ Penicillin Allergy
☐ Latex Allergy
Medication Allergies?
Please list_____
_____
_____
Has your child had any problems with previous dental work? y ☐ n ☐
Explain_____

Does your child brush daily? How many times.
☐ 1X ☐ 2X ☐ 3X
Floss? Yes ☐ No ☐

Does your child have the following habits?

☐ Thumb/finger sucking
☐ Lip/cheek biting
☐ Nail biting
☐ Bottle/pacifier habit
☐ Other (please list)
_____
_____
Orthodontic treatment?
When_____
For how long _____

•Please list any medications your child is currently taking:_____
_____

• Name of Physician: _____ Phone:_____

• Is your child now under the care of a physician? ☐ Yes ☐ No If yes, please explain:_____
_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. It is my responsibility to inform this office of any changes in my child's medical status.

_____ Date: _____
Signature of patient, parent/guardian

Referral Information

Whom may we thank for referring you to our practice? _____

Responsible Party Information

The following is for: ☐ Father ☐ Mother ☐ Guardian/Other

Name: _____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other _____

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ Ext:_____ Best time to call: _____

Address: _____
Street Apartment #

_____
City State Zip Code

Employment Information

The following is for: ☐ Father ☐ Mother ☐ Guardian/Other

Employer Name: _____ Occupation: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Insurance Plan Name and Address: _____

_____

Secondary

Name of Insured: _____
Last First MI

Insured's Birth Date: _____ ID #: _____ Group #:_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Insurance Plan Name and Address: _____

_____

Consent for Services

I hereby certify that I have read and understand the above information and have answered the questions accurately. I understand that giving incorrect information could be dangerous to my child's health. I understand that this information will be held in the strictest of confidence, and that it is **my responsibility** to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services, including local anesthetic that my child may need during diagnosis and treatment. I authorize the dentist to release records and any information he deems necessary to any third party payers and/or health practitioners. I authorize and request that my insurance carrier pay the dentist directly benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services and I agree to be responsible for the unpaid remaining balance. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ Date: _____ Relationship to Patient: _____
Signature of parent or guardian

_____ Date: _____ Relationship to Patient: _____
Signature of guarantor of payment/responsible party