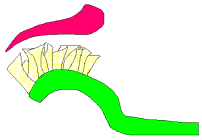
Louis Bartimmo, DMD
Caroline Vizcaya, DMD
535 Plandome Rd - Door #5
Manhasset, NY 11030
Ph: 516-627-5442 / Fax: 516-869-0962
www.MYDENTISTCARES.com



Date:					
Child's name:		Nick name:		Sex:	Grade:
D.O.B.	Age:	Address:		Zip:	School:
Father's name:	Mother's name:	Brother's name:	Sister's name:		
Home Telephone:	Work Telephone:	E-mail:	Reason for Visit:		
Child's favorite hobby:	Child's favorite sport:	Pet's name:			
Dental insurance carrier's name:	Insurance address:	Insurance telephone:	Group number:		
Whom may we thank for referring you:					
Employer:	Employer address:	Employer telephone:	Insurer's SS#:		

Dental History

Date of last dental visit?	For what reason?	Does your child brush daily?	Yes	No

Do you assist your child with brushing?	Yes	No	Any lost teeth?	Yes	No
Any previous unhappy medical or dental visit?	Yes	No	How often do you assist your child brush?		
Has your child complained about any dental problems?	Yes	No	Does your child use dental floss?	Yes	No
Any injuries to mouth, teeth or head?	Yes	No	Are disclosing tablets used?	Yes	No
What has been the child's attitude to doctors' visits?					
How does your child receive fluoride?			Vitamin(s)?	Yes	No
Water supply?	Yes	No	Tablets?	Yes	No
Toothpaste?	Yes	No	None?	Yes	No
Dentist or Hygienist?	Yes	No	Other:		

Medical History

Are all immunizations current	Yes	No

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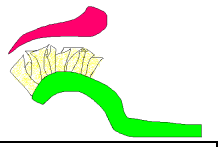

Child's physician:	Physician's number:	Physician's address:

Date of last complete physical examination?	Results
Is your child in good health?	Is your child presently under care by a physician?
Is your child receiving any medications or drugs?	What is your child's weight?
Height?	Has your child ever been hospitalized?
Has your child ever had surgery?	Current eating habits (briefly explain)
Are there any psychological or emotional problems you would like to bring to our attention?	
Does your child have or has any of the following health problems?	
Rheumatic fever or Rheumatic heart disease	
Congenital heart disease or heart murmur	

Allergies:

Food, dust, etc
Drug, i.e. (penicillin, etc)
Unknown
Asthma or hay fever
Arthritis or rheumatism (painful swollen joints)
Diabetes or blood sugar problems
Any prolonged bleeding or bruises easily
Kidney or bladder problems
If yes, please explain:
Anemia or blood disorders
Tuberculosis or pneumonia
Liver problems, jaundice or hepatitis

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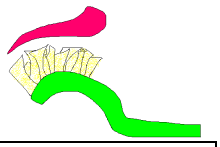

Glandular or hormonal problems
Accidents or severe infections
Convulsion, seizures, fainting or epilepsy
Speech, learning or hearing disorders
Childhood illnesses
Other, if so explain

Summary: (for doctor's use)

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information the dentist should be aware of that has **not** been covered above.

This office has no relationship with your insurance company in establishing how much you will be reimbursed for dental treatment. We have no power to deal with them. This can only be done by the purchaser and user of the plan. If you have a problem with poor insurance coverage, please complain to the insurance company and your plan purchaser. This will be much more effective. Perhaps you can influence the proper people to buy a better plan in the future.

The patient / guardian are ultimately responsible for paying the entire fee for dental treatment. The insurance company is obligated to you, not the dentist. Your insurance company has not requested treatment, you have. Our obligation is to you, the dental patient. We must examine, diagnose and treat you. We cannot allow dental treatment to be dictated by a third party. It is your health we must be concerned about and there is no room for compromise.

We are happy to help you receive the maximum benefits you are allowed from your dental coverage. We have had years of experience in dealing with insurance carriers and know how to properly fill out the dental forms. In order for us to be successful in submitting your insurance for your reimbursement, you must bring in an insurance form with your portion completed and signed.

I have been informed about the **HIPAA Notice of Privacy Practices** that this office has put into effect (April 14, 2003) and give consent.
(A copy of the HIPPA Notice of Privacy Practices is in the waiting room and on this site or a copy can be attained at the front desk)
I consent to sharing my PHI with family members_____(Please Initial)
I consent to sharing my PHI and x-rays with my insurance co. and referring doctors_____(Please Initial)

I have read this information and understand it.

Print Name:_____

Sign:_____Date:_____
All information that I have given the office is complete and accurate. That I have given the office is complete and accurate.