MARIA NIKOLICH, D.M.D.
Adult and Children's Dentistry and Orthodontics
236 North Woodbury Road
Pitman, NJ. 08071

Patient's Name:_____Nickname:_____
Date of Birth:_____Age at Present:_____
Home Address:_____
Telephone:Home:_____Business:Mom:_____Dad:_____
Father's Name:_____Occupation:_____
Mother's Name:_____Occupation:_____
With whom does the child reside:_____
Brother's and Sister's Names and Ages:_____
Name of School:_____Grade:_____
Who may we thank for referring you to our office:_____

MEDICAL HISTORY:

Name of Child's Physician or Pediatricians:_____
Address:_____Telephone:_____
Is the child currently under the care of physician?_____
What is the condition being treated?_____
Has the child been in the hospital or had surgery?_____
Has the child had an unusual reaction or allergy to medications such as penicillin, aspirin, or local anesthetics? _____

Has your child experienced any of the following medical problems?
(CIRCLE THOSE WHERE "YES" APPLIES)

Abnormal bleeding	Convulsions
Diabetes	Tuberculosis
Anemia	Epilepsy
Asthma	Exposed to HIV, but Neg.
Cancer	Handicaps/Disabilities
Allergies	Hearing Impairment
Congenital Heart Defect	Heart Murmur
Hemophilia	Immunizations Current
Hepatitis	Mononucleosis
Rheumatic Fever	Kidney/Liver Problems

DENTAL HISTORY:

Reason for today's visit?_____

Is today your child's first dental visit?_____
How old was your child when first taken to the dentist?_____
How often does your child brush_____and floss_____his/her teeth?
Has your child experienced any facial injuries?_____
Does your child get headaches and how often?_____
Does your child play any sports and does he/she wear a protective mouthpiece?__

Does/did your child have any of the following habits? (CIRCLE THOSE WHERE "YES" APPLIES)

Lip sucking/biting	Baby Bottle Syndrome
Nail biting	Thumb/Finger Sucking
Chewing on Objects	Tongue/Cheek Biting
Mouth Breather	Speech Problems
Clenching/Grinding Teeth	Tongue Thrust
Used Pacifier?	Breast Fed?

How many months of exclusive breastfeeding?
How many months of partial breastfeeding?

PERSONAL HISTORY:

Child's hobbies:_____
Are there any behavior problems we should be aware of?_____

By signing this form I acknowledge that it was filled to the best of my knowledge. It will be my responsibility to notify Dr. Nikolich of any changes in my child's medical status. I authorize the dental staff to perform any treatment necessary.

ASSIGNMENT AND RELEASE: I certify that I, and/or my dependant(s), have insurance coverage with _____and assign directly to Dr. Nikolich all insurance benefits, if any, otherwise directly payable to me for services rendered. I authorize the use of my signature on all insurance submissions.

_____

Date Signature of Parent(Guardian)