PITTSFORD PEDIATRIC DENTISTRY

DENTISTRY FOR CHILDREN

TOBEY VILLAGE OFFICE PARK 90 OFFICE PARKWAY PITTSFORD, NEW YORK 14534
(585) 383-0640

Acct _____

THESE QUESTIONS WILL AID US TO BETTER UNDERSTAND YOUR CHILD. THANK YOU!

Child's Name _____ Sex _____ Nickname, if any _____

Age _____ Birthday _____ Place of Birth _____

Attends what school _____ Grade _____

Name and age of brothers/sisters _____

Child's Physician or Pediatrician _____ Phone _____

Family Dentist _____ Cell Phone _____

How did you hear about our office? _____ Cell Phone _____

Purpose of call _____ Email _____

Name of child's pet and child's hobby _____

Yes No **Check Yes or No in response to the following questions …**

☐ ☐ 1. Does your child have a health problem, no matter how insignificant? Explain

☐ ☐ 2. Has you child ever been in the hospital or had surgery? Explain
☐ tonsils ☐ adenoids ☐ implants ☐ other _____

☐ ☐ 3. Has you child ever had any of the following?
☐ Hepatitis ☐ Heart Disorder ☐ Heart Murmur ☐ Allergies ☐ Rheumatic Fever
☐ Convulsive Disorder ☐ Liver Disorder ☐ Blood Disorder ☐ Kidney Disorder
☐ Asthma ☐ Jaw Problems ☐ HIV ☐ ADD, ADHD ☐ GERD
☐ Diabetes ☐ Hypoglycemia ☐ Hearing Disorder ☐ Thyroid ☐ Sensory Issues
☐ Allergies to Bananas, Chestnuts, Avocado, and/or Kiwi

☐ ☐ 4. Is your child taking Medication? If so, what? _____

☐ ☐ 5. Has your child had any unfavorable reaction to drugs, including antibiotics and local anesthetic solution? (please specify) _____

☐ ☐ 6. Has your child had any unfavorable reaction to latex products?

☐ ☐ 7. Does your child have an emotional or learning disorder? Explain _____

☐ ☐ 8. Does your child have Autism or Asperger's Syndrome?

☐ ☐ 9. Has your child any history of thumb sucking, finger sucking, lip biting, nail biting? (please circle)

☐ ☐ 10. Does your child have a bad bite?

☐ ☐ 11. Did either parent need to have braces?

☐ ☐ 12. Did either parent have a Temporomandibular joint (TMJ) problem?

☐ ☐ 13. Has either parent had a lot of decay?

☐ ☐ 14. Has your child had any unfavorable experiences in a dental office or medical office? (please circle)

☐ ☐ 15. Has your child had a toothache recently?

16. Date of last dental care _____ Where? _____

17. Were x-rays taken? _____ Previous dentist phone number _____

Notes:

Child's home phone number _____ Email address: _____

Parent/Guardian's name _____ Phone (same as above) or _____

Parent/Guardian's address _____ cell number: _____

Parent/Guardian's name _____ Phone (same as above) or _____

Parent/Guardian's address _____ cell number: _____

Former address (if less than two years) _____

How long did you live there? _____

Parent/Guardian's Employer _____ SS# _____

Business Address _____ Phone _____

Parent/Guardian's Employer _____ SS# _____

Business Address _____ Phone _____

If you have previously completed this form for another child, please give that child's name _____

Do you have dental insurance? ☐ Yes ☐ No

over ☞

Dental Insurance Information

Primary Insurance	*Additional Insurance*
Name of Insured	Name of Insured
Relationship to Patient	Relationship to Patient
Insured's Birth Date	Insured's Birth Date
Soc. Sec. #	Soc. Sec. #
Employer	Employer
Business Address	Business Address
Date Employed/Occupation	Date Employed/Occupation
Insurance Co.	Insurance Co.
Group #	Group #
Ins. Co. Address	Ins. Co. Address

OUR OFFICE POLICY

Our financial policy has been set up to prevent misunderstandings. We like to acknowledge patients who take a responsible approach to paying their dental care.

1. Full payment is expected at the time of service unless other arrangements are made.
2. The account is subject to a billing charge of 1.5% per month, minimum $4.00 on unpaid balances after 30 days.
3. The account is subject to a $25.00 service charge if an appointment is broken or cancelled within 24 hours and a $35.00 service charge for returned checks.
4. I will be responsible for any bill incurred on this child for dental treatment. It is understood and agreed that, in the event any outstanding balance has to be referred to a collection agent or attorney for recovery, I will be fully responsible for any and all costs, including, but not limited to attorneys fees.
5. I authorize Dr. Kochman or his staff to take photographs of my child's care and treatment which may be used for the advancement of pediatric dentistry educational viewing or for use in dental publications. Dr. Kochman may not reveal my child's identity without my permission. Authorization is hereby granted as such.
6. I authorize Dr. Kochman to release any information including the diagnosis and records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or health practitioners. I request my insurance company to pay the dental group benefits directly to me and I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to my child.
7. Because your child is a minor, it becomes necessary that a signed permission is obtained from a parent/guardian before any or all necessary dental service can be started and accomplished by Dr. Kochman or the staff of Pittsford Pediatric Dentistry.

Please sign below to indicate that you have read and fully understand the above policy.

_____ _____

Signature of Parent or Guardian Date