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 ______ Pediatrician Phone ______

Family Dentist ______

How did you hear about our office? ______

Purpose of call ______

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, 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:	Parent/Guardian's name:
Phone (same as above) or:	Phone (same as above) or:
Cell Number:	Cell Number:
Home Address:	Home Address:
Employer:	Employer:
Social Security #:	Social Security #:
Business Address:	Business Address:
Business Phone #:	Business Phone #:
Former Address (if less than 2 years):	Former Address (if less than 2 years):
How long did you live there?:	How long did you live there?:

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 the staff of Pittsford Pediatric Dentistry 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. Pittsford Pediatric Dentistry may not reveal my child's identity without my permission. Authorization is hereby granted as such.
6. I authorize Pittsford Pediatric Dentistry 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 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