

Demographic Information

Patient _____ Today's Date _____

Name child would like to be called _____ Home Phone _____

Birthday _____ Age _____ Sex _____ Cell Phone _____

Guardian's Email _____

Home Address _____

street

town

state

zip code

Names and ages of other children in family _____

School _____ Grade _____

Guardian 1: _____ Relation to patient _____

Employer _____ Phone _____

Guardian 2: _____ Relation to patient _____

Employer _____ Phone _____

Who has legal custody of patient? _____ Dental Insurance: Yes No

Person responsible for payment of account _____ SS# _____ DOB _____

Name of child's physician/group _____ City/St _____ Ph # _____

Whom may we thank for referring you to us? _____

What is the reason for your child's dental visit? _____

Health History

Yes No Is your child in good health? Date of last physical exam _____

Yes No Has your child ever had a health problem? _____

Yes No Has your child ever been hospitalized? Please give reason and dates _____

Yes No Is your child allergic to anything? _____

Yes No Is your child currently taking any medications? Please give medication, dose and reason _____

Yes No Were there any problems at birth? _____

Please circle if your child has been treated for any of the following:

- | | | | |
|------------------|--------------------------|---------------------|-----------------------|
| Heart disease | Bleeding/transfusions | Asthma/breathing | Blood dyscrasias |
| Liver/GI disease | Anemia | Diabetes | AIDS |
| Kidney disease | Rheumatic fever | Hepatitis | Mental delays |
| Speech/hearing | Seizures | Cleft lip/palate | Physical delays |
| Eyesight | Congenital birth defects | Personality/social | Other problems |
| Cancer/tumors | Recurrent headaches | Frequent infections | Adverse Drug reations |
| Cerebral palsy | Sianificant iniuries | Endocrine/arowth | Autism |



Please elaborate on any items circled: _____

Office use only

Dental History

- Yes No Has your child ever been to the dentist? Date of last xrays (if taken) _____
Name of dentist and date _____
- Yes No Has your child experienced any unfavorable reaction from previous dental
care? Explain _____
- Yes No Does your child suck a finger, thumb or pacifier?
- Yes No Does your child have pain with chewing, yawning, or wide opening?
- Yes No Does your child's jaw make noise and is pain associated with the sounds?

Please check if your child is having problems with any of the following:

Cavities	Toothache	Teeth Sensitive
Trauma	Gum Infections	Color of teeth
Orthodontics	Jaw Sounds	Other

Comments: _____

Fluoride History

- Yes No Is your home water supply fluoridated?
- Yes No Does your child use a fluoride toothpaste?
- Yes No Do you give your child any other form of fluoride? What? _____
- Yes No Does your child participate in a school fluoride rinse program?

Consent for Dental Treatment

I request and authorize Dr. Rossitch to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Rossitch to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Rossitch will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone.

I hereby authorize any payment of dental benefits to be made directly to Rossitch Pediatric Dentistry. I also understand that any amount not covered by my insurance policy is my responsibility and is due at the time of treatment. I authorize treatment to be rendered and assume financial responsibility. I acknowledge that all non-current balances and accounts over 60 days will be charged a service charge of 1.5 % per month (18% per year) on the unpaid balance. The cost incurred in collecting this account including court costs, agency fees and attorney fees will be added to the balance due.

_____ I acknowledge the notice of privacy policies and understand that I may receive a copy upon request.

_____ I understand I may refuse to sign this acknowledgement.

(Initial)

Signature _____ Date _____