Michael A Rossitch DDS MS PC **Pediatric Dentistry**
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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	Significant injuries	Endocrine/growth	Autism

Please elaborate on any items circled:_____
_____
_____
_____

Office use only

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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** _____