Rossitch Pediatric Dentistry **Michael A Rossitch DDS, MS, PC**
3698 Largent Way Suite 201 Marietta, GA 30064 **Phone (770)420-6565 Fax (770)420-6570**

Patient Name: _____ today's Date_____
Name Child would like to be called_____ Home Phone_____
Birthday_____ Age_____ Sex_____ Cell Phone _____
Primary contact Email_____
Home Address_____
Street City State Zip Code
Names and ages of siblings: _____
Parent/Guardian 1:_____DOB_____SSN_____/___/_____
Employer: _____ Primary Phone: _____-____-_____Relationship_____
Parent/Guardian 2:_____DOB_____SSN_____/___/_____
Employer:_____ Primary Phone:_____-____-____ Relationship_____
Who has legal custody of patient_____ Dental Insurance: Yes No Insurance Company:_____
Person Responsible for payment on account:_____SSN#:_____DOB_____
Name of child's Pediatrician_____City/State_____Phone_____
What is the reason for your child's visit?_____
Who can we thank for referring you to our office?_____

Health History

Is your child in good health? YES NO Date of last physical Exam_____
Has your child ever had a health problem? YES NO If Yes, Please Explain_____
Has your child ever been hospitalized? YES NO If Yes, Please give reasons and date(s)_____
_____

Is your child allergic to any medication(s)? YES NO If yes, please list medication(s)_____

Does your child have any food allergies? YES NO If yes, please list_____

Is your child taking any medications? YES NO If yes, please list name, dose and reason_____

Has your child ever been treated for any of the following? (Please circle)

Heart Disease	Bleeding/Transfusion	Asthma/Breathing	Liver/GI disease
Anemia	Diabetes	AIDS	Kidney Disease
Rheumatic Fever	Hepatitis	Mental Delays	Physical Delays
Speech/Hearing	Seizures	Cleft lip/palate	Eyesight
ADD/ADHD	Congenital Birth Defects	Cancer/Tumors	Recurrent Headaches
Frequent Infections	Adverse Drug Reactions	Autism	Cerebral Palsy
Significant Injuries	Endocrine/Growth	Personality/Social	Other Problems

Please explain any circled items: _____
_____
_____
_____

Dental History

Has your child ever been to the dentist? YES NO Name of Dentist: _____

Date of last exam and x-rays (if taken) _____

Has your child ever has an unfavorable reaction from previous dental care? YES NO Explain_____

_____

YES NO Does your child suck a finger, thumb or pacifier?

YES NO Does your child have pain when chewing, yawning or opening wide?

YES NO Does your child's jaw make noise and is pain associated with these sounds?

YES NO Is your child having problems with any of the following? (Please Circle)

Cavities	Toothache	Sensitivity	Trauma
Gum Infections	Color of Teeth	Jaw Sounds	Orthodontics

Comments: _____

_____

Fluoride History

YES NO Is your home water supply fluoridated?

YES NO Does your child use fluoride toothpaste?

YES NO Does your child use any other form of fluoride? What kind: _____

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 and 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 balance due.

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

(Initial)

_____ I understand I may refuse to sign this acknowledgement.

(Initial)

Signature of Parent/Guardian_____**Today's Date**_____