WELCOME

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!

1. Tell Us About Your Child

Today's Date: ____________________

Child's Name: ____________________ (Last / First / MI)

Child's Birthdate: ____/____/____ Child's Age: ____________

Nickname: ____________________ ☐ Male ☐ Female

School: ____________________ Grade: ____________

Hobbies: ____________________

Child's Home #: (_____)____________ SS #: ____________

Child's Home Address: ____________________ Apt / Condo #

____________________ City / State / Zip

2. General Information

Who is accompanying the child today?

Name: ____________________ Relation: ____________

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we Thank for referring you? ____________________

Other siblings: ____________________

Previous / Present Dentist: ____________ Last Visit Date ________

Dentist's Phone #: (_____) ____________

Relative or Friend not living with you:

Name: ____________________ Phone: (_____) ____________

Address: ____________________ City / State / Zip

3. Parent's Information

Person Responsible for Account: ____________ Parent's Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

☐ Father ☐ Step Father ☐ Guardian

Name: ____________________ Birthdate:___/___/___

Address: (If different than Child's) Hm #: (_____) ____________

____

____

SS #: ____________ DL #: ____________

Wk #: (_____)________ Ext: ______ Cell/Other #: (_____) ________

Email: ____________________

Employer: ____________________

Employer's Address: ____________________

____________________ City / State / Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: ____________________

Insurance Address: ____________________

____________________ City / State / Zip

Insurance Phone: (_____) ____________

Group # (Plan, Local, or Policy #): ____________________

☐ Mother ☐ Step Mother ☐ Guardian

Name: ____________________ Birthdate:___/___/___

Address: (If different than Child's) Hm #: (_____) ____________

____

____

SS #: ____________ DL #: ____________

Wk #: (_____)________ Ext: ______ Cell/Other #: (_____)________

Email: ____________________

Employer: ____________________

Employer's Address: ____________________

____________________ City / State / Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: ____________________

Insurance Address: ____________________

____________________ City / State / Zip

Insurance Phone: (_____) ____________

Group # (Plan, Local, or Policy #): ____________________

4. Release

I certify that my child is covered by ____________________ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

____
Signature of Parent or Guardian Date

Continued on Back

5. Dental History

Why did you bring the child to the dentist today? ______________

____

____

Has the child ever taken any diet pills such as Phen-Fen? (Also known as Redux or Pondimin.) If so, when? ______ ☐ Yes ☐ No

Is the child currently in pain? ☐ Yes ☐ No

Does the child require antibiotics before dental treatment? ☐ Yes ☐ No

Has the child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician: ______________

Phone #: ______________ Date of Last Visit: ______________

Is the child currently under the care of a physician? ☐ Yes ☐ No

Please describe the child's current physical health: ☐ Good ☐ Fair ☐ Poor

Please list all prescription / over the counter or herbal supplement drugs that the child is currently taking: ______________

____

Aside from items listed, please list all drugs/things that the child is allergic to:

____

____

Yes No Latex   Yes No Metals/Nickel   Yes No Plastic

6. Medical History

Has the child experienced the following medical problems?

Y	N	Abnormal Bleeding / Hemophilia	Y	N	Heart Murmur
Y	N	ADD/ADHD	Y	N	Hepatitis
Y	N	AIDS/HIV+	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	Hives
Y	N	Any Hospital Stays/Operations?	Y	N	Kidney Problems
Y	N	Artificial Bones/Joints/Valves	Y	N	Liver Problems
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Cancer	Y	N	Lupus
Y	N	Chicken Pox	Y	N	Measles
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Convulsions	Y	N	Mononucleosis
Y	N	Diabetes	Y	N	Prosthetics
Y	N	Epilepsy	Y	N	Rheumatic Fever
Y	N	Exposed to HIV, but Neg.	Y	N	Scarlet Fever
Y	N	Handicaps/Disabilities	Y	N	Skin Rash
Y	N	Hearing Impairment	Y	N	Tuberculosis (TB)

Are the child's immunizations current? ☐ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Please discuss any serious medical problems the child experiences/ed:

____

____

Does/did the child experience any of the following?

Y	N	Breast Fed	Y	N	Nursing Bottle Habits
Y	N	Chewing on Objects	Y	N	Speech Problems
Y	N	Clenching/Grinding Teeth	Y	N	Thumb/Finger Sucking
Y	N	Lip Sucking/Biting	Y	N	Tongue/Cheek Biting
Y	N	Mouth Breather	Y	N	Tongue Thrust
Y	N	Nail Biting	Y	N	Used Pacifier

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

____
Signature of Parent or Guardian   Date

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the parent/guardian and patient named herein.

______________ ______________
Signature of Dentist   Date

Dentist's Comments: ______________

____

____

Medical History Update

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N
If Yes, please explain. ______________

____

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N
If Yes, please explain. ______________

____

____
Parent/Guardian Signature   Date

____
Dentist Signature   Date

____
Parent/Guardian Signature   Date

____
Dentist Signature   Date

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PEDIATRIC DENTAL ASSOCIATES OF MANHATTAN

CREDIT CARD ON FILE POLICY

At Pediatric Dental Associates of Manhattan, we require keeping your credit or debit card on file as a convenient method of payment for the portion of services that your insurance does not cover, but for which you are liable. Furthermore, an "outstanding balance" charge of 1.5 percent of the total amount due will be automatically added for each bill that is sent out.

Your credit card information is kept confidential and secure and payments to your card are processed only after the claim has been filed and processed by your insurer, and the insurance portion of the claim has been paid and posted to the account.

I authorize Pediatric Dental Associates of Manhattan to charge the portion of my bill that is my financial responsibility to the following credit or debit card:

■Amex ■Visa ■MasterCard ■Discover

Credit Card Number ____________________

Expiration Date ______/______ CVC CODE ____________________

Cardholder Name ____________________

Signature ____________________

I, the undersigned, authorize and request Pediatric Dental Associates of Manhattan to charge my credit card, indicated above, for balances due for services rendered that my insurance company identifies as my financial responsibilities and for the $75 broken appointment fee if 24 hours' notice is not given.

This authorization relates to all payments not covered by my insurance company for services provided to me by Pediatric Dental Associates of Manhattan.

This authorization will remain in effect until I cancel. To cancel, I must give a 30 day notification to Pediatric Dental Associates of Manhattan in writing and the account must be in good standing.

Patient name (PRINT): ____________________
Parent/Guardian Name (PRINT): ____________________
Parent/Guardian Signature: ____________________
Date: ____________________

PEDIATRIC DENTAL ASSOCIATES
PEDIATRIC DENTISTRY

30 EAST 40TH STREET, SUITE 503
NEW YORK, NEW YORK 10016

TELEPHONE (212) 986-2039

CONSENT

I give this practice my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies and for health care operations like quality reviews.

I have been informed that I may review the practice's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice has the right to change their privacy practices and that I may obtain any revised notices at the practice.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice is not required to agree to the request. If the practice agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: ______________________________ Date: ____________________

Patient, parent or legal guardian

Print: ________________________________ Date: ____________________

If signed by patient representative, state relationship to patient ______________________

Pediatric Dental Associates of Manhattan
30 East 40th Street, Suite 503
New York, NY 10016
212-986-2039

Insurance Notice

Dear Parent or Legal Guardian of__________________________________

In order to provide the best dental care for your child or young adult, the doctor may recommend certain procedures that may not be covered by your insurance. These may include tooth-colored fillings, orthodontic appliances, sedative techniques and others. It is your responsibility to check your coverage, ask for a pre-treatment estimate and to provide correct and active insurance information. You will be financially responsible for non-covered treatment.

Signature: ____

Date: ____