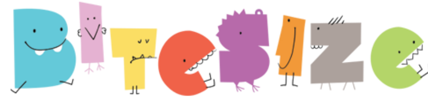

PEDIATRIC DENTISTRY

**PEDIATRIC PATIENT INFORMATION:** DATE:_____/_____/_____

Name: ____________________________________________ Nickname:__________________________________________

Date of Birth: _____/_____/_____ Sex: M ☐ F ☐ Child's School: _________________________________________

Address: ____________________________________________________________________ Apt #: ___________________

City: ______________________________________________________ State:___________ Zip Code: _______________

Home Phone #: (______) _______-__________ ☐ Cell Phone#: (______) ________-__________ ☐ (check preferred #)

Siblings who are patients of our practice: ____________________________________________________________________

Whom may we thank for referring you to our office?______________________________________________

**PATIENT'S PARENT INFORMATION:**

Name:__________________________________________ Name:_____________________________________________

Date of Birth: ______/______/_______ Date of Birth:______/______/______

Occupation:_____________________________________ Occupation: ________________________________________

Work Phone #: (_______) ________-________________ Work Phone#: (_______) _________-__________________

Cell Phone#:(_______) _________ -_________________ Cell Phone#: (_______) _________-__________________

Email: __________________________________________ Email: _____________________________________________

**If any parent's address is different from the patient's home address, please specify below:**

Parent's Name: _________________________________________________________________________________

Address: _________________________________________________________________ Apt. #_______________

City: ___________________________________________________ State:_________ Zip Code:______________

**Emergency Contact (name and phone number):**_____________________________________________________

**MEDICAL HISTORY:**

Date of last physical checkup:______/______/_______ Date of last dental checkup:______/______/______

Name of Pediatrician: ________________________________________ Phone #: (_______)_________-_____________

Address: _______________________________________________________________ Suite #: _____________________

City: _____________________________________________ State: ______________ Zip Code: ___________________

**Has your child been diagnosed with any of the following? Please check all that apply:**

□ ADD / ADHD
□ Allergies Fainting
□ Anemia
□ Asthma Heart murmur
□ Autism
□ Bleeding Disorder (Prolonged Bleeding)
□ Cancer
□ Cardiac Condition
□ Coordination Disorder (CP)
□ Diabetes Renal
□ Down Syndrome
□ Ear Infections
□ Hearing loss
□ Hepatitis
□ Intestinal Problems
□ Kidney Disease
□ Learning Disability
□ Liver disease
□ Malignancies
□ Respiratory Problems
□ Rheumatic Heart Disease
□ Rheumatoid Arthritis
□ Seizure Disorder
□ Sinus problems
□ Speech Delay
□ Tuberculosis
□ Thyroid Problems
□ Thyroid Problems
□ Visual Disorder

**DAILY MEDICATIONS (PLEASE LIST ALL):**_____________________________________________________________________

Any Major/ Minor Surgery? Yes □ No □ If yes, please explain: ______________________________________________

Any Hospitalizations? Yes □ No □If yes, please explain:____________________________________________________

Was the term of your pregnancy and birth of your child normal? Yes □No □

If not, please explain: ___________________________________________________________________________________

Has your child had any disease or medical issues not mentioned above? Yes □N□

If yes, please explain: _______________________________________________________________________

Has your child had an unusual experience with any anesthetic? Yes □ No □

If yes, please explain: _______________________________________________________________________

Does your child undergo regular MRI's for any reason? Yes □No □

**Allergies to Medication** (PLEASE LIST ALL):__________________________________________________________

**Latex Allergy/ Food Allergy**: _________________________________________________________________

**DENTAL HISTORY:**

Is this your child's first visit to the dentist? Yes □ No □

Purpose of today's visit: ______________________________________________________________________

Is your child currently having any dental discomfort? Yes □ N □

If yes please explain: ______________________________________________________________________

How many times a day does your child brush his/her teeth? ________ With adult assistance? Yes □ No □

Does your child floss his/her teeth? __________

Is your child using a bottle? Yes □ No □ If yes, contents: __________ Is your child breastfed? Yes □ No □

Does your child have any of the following habits: Finger/thumb sucking Pacifier use? Yes □ No □

Does your child drink tap water, bottled water, or both? Tap water □ Bottled water □ Both □

Does your child take vitamins supplemented with fluoride? Yes □ No □

Is your child currently being treated by an Orthodontist? Yes □ No □

Name of Orthodontist: ______________________________________________________________________

How does your child behave with the pediatrician? ________________________________________________

**Consent for Treatment**

I hereby give my consent to Rafay Hussain, D.D.S., Rupin Malhotra, D.D.S, and their associates to treat my child. I authorize the treating dentist to provide any information to other doctors for the purpose of consultation. I understand that prior to providing any treatment I will be advised about it by the dentist or hygienist, that I may ask questions concerning it, and that I may revoke this consent before treatment is provided. I understand that I may ask for a full recital of any or all risks attendant to the care of the patient.

Parent's Signature:_______________________________________________ Date: ______/______/______

Print Parent's Name: ______________________________________________

For future appointments, if you are planning to send your child with someone other than a legal guardian, please provide the following information:

Name of authorized person:______________________________________________________________

Please do not write below this line

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Reviewed By: _______________________________________________D.D.S., R.D.H. Date:______/______/______

**OFFICE POLICIES:**

**Missed appointments**:

If you are unable to keep your child's appointment, we would appreciate at least 24 hours notice if at all possible. This will help us utilize that time for another patient who requires an appointment. We would be glad to reschedule your appointment at a more convenient time if necessary. We reserve the right to charge for missed appointments.

**Emergencies:**

Unfortunately dental emergencies do arise. We will make every effort to assess your child's emergency on the phone and make him/her an appropriate appointment. Based on our experience and the type of emergency we can determine how urgently we need to see your child. We prefer to see emergencies in the earlier part of the day when the office tends to be quieter. We also ask for your patience when we might be delayed in seeing your child due to an urgent situation with another patient.

**Financial Policy:**

We are delighted to welcome your child to our practice and we are pleased that you have chosen us to serve your child's dental needs. The following is a statement of our financial policy, which we require you to read and sign and the bottom of this page:

Payment is expected at the time services are rendered; the parent who accompanies the patient to the appointment will be responsible for payments. If you are unable to be with your child at the time of his/her appointment, payment arrangements should be made prior to the dental visit.

If you have concerns or questions regarding this policy, please feel free to discuss this with our head administrator.

It's our pleasure to process your dental insurance, however, anything denied by the dental insurance is the patients responsibility.

**Payment methods**:

We accept American Express, Discover, Master Card, Visa, and Cash.
*All returned checks are subject to a twenty-five dollars service charge Credit Card Authorization:
□ I do not authorize any credit cards to be on file.
□ I hereby authorize Bitesize Pediatric Dentistry to keep my credit card on file, in which it could be used to charge any visits my child has, as well as to clear any balances on my account.
We will mail you a statement with a copy of your credit card receipt.

Cardholder's Name: ______________________________________________

Card type: AMEX □ - DISCOVER □ - MC □ - VISA □

Card Number: ____________________________________________________ Expiration Date:______________

Billing Zip Code:________________________

Cardholder's Signature: ___________________________________________ Date: _____/_____/_____