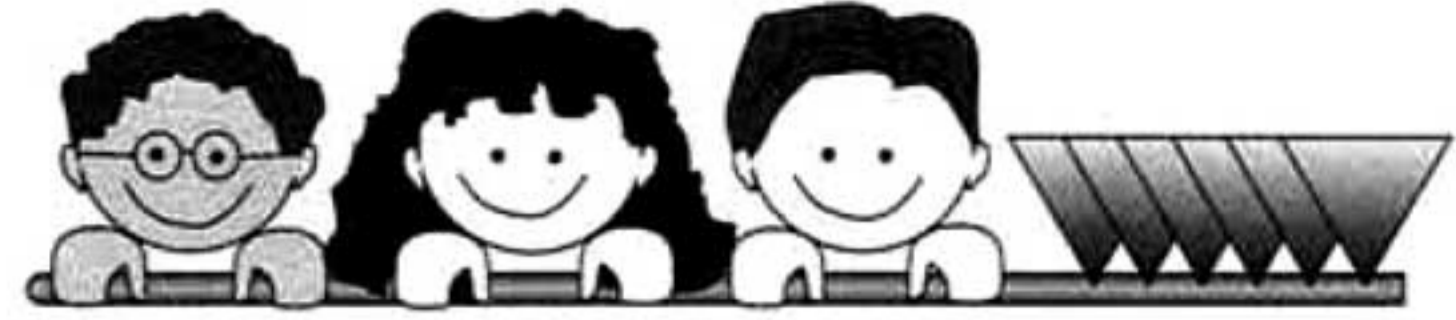


WELCOME TO OUR PRACTICE!

Child's Information

Last Name: _____ MI: _____
First Name: _____ Nickname: _____
Street: _____ City: _____
State: _____ Zip: _____ Phone: _____
Date of Birth: _____ Sex: M F
Referred By: _____




Rockland Pediatric Dental and Orthodontics

238 North Main Street
New City, NY 10956
(845) 634-8900

Parent/Guardian (Primary Insurance Holder)

Title: Mr. Mrs. Ms. Dr.
Last Name: _____
First Name: _____ MI: _____
Social Security #: _____ Sex: M F
Date of Birth: _____ Age: _____


Address Of Parent/Guardian (Primary Ins. Holder)


Street: _____
City: _____
State: _____ Zip: _____
Home Tel #: _____ 
Relationship to Patient: _____

Employer

[Of Parent/Guardian (Primary Ins. Holder)]

Insurance

Name: _____
Business Tel #: _____  Ext #: _____
Group #: _____
Address: _____

DMO PPO Co-Pay \$ _____
Name: _____
Policy #: _____
Group #: _____
Address: _____
_____ Tel #: _____ 

To our patients and parents:

Although dentists primarily treat the area in and around the mouth, it is a part of the entire body. Health problems that your child may have or medication that your child may be taking, could have an important interrelationship with the care that he/she will be receiving. Thank you for answering the following questions. Your answers are for our records only and will be considered confidential.

Whom may we thank for referring you? _____

Child's favorite games, hobbies, pets, TV shows, toys, etc

HAS YOUR CHILD HAD OR CURRENTLY HAVE.....				NOTES	HAS YOUR CHILD HAD OR CURRENTLY HAVE.....			
	Yes	No				Yes	No	NOTES
1	Rheumatic Fever?				17	HIV Positive?		
2	Heart Murmur?				18	Hives/Skin Disorder?		
3	Congenital Heart Problems?				19	Thyroid/Glandular Problems?		
4	Other Cardiac Disease?				20	Ear/Hearing Problems?		
5	Anemia?				21	Visual (eye) Disorder?		
6	Asthma?				22	Tumors?		
7	Respiratory Problems?				23	Rheumatoid Arthritis?		
8	Unusual Bleeding/Blood Disorder?				24	Stomach/Intestinal Disorders?		
9	Diabetes?				25	Ulcers?		
10	Convulsions?				26	Nervous/Neurological Disorders?		
11	Dizziness/Fainting?				27	Muscular Disorder?		
12	Coordination Disorder?				28	Staphylococcal Infections?		
13	Hepatitis?				29	Hyperactivity?		
14	Jaundice?				30	Learning Disability?		
15	Liver/Kidney Disorder?				31	Temper Tantrums?		
16	Tuberculosis?							

What childhood illnesses has your child had? _____
 Other diseases not mentioned above? _____

MEDICAL UPDATE

DATE	CONDITION	COMMENTS	SIGNATURE

OFFICE POLICIES

- We expect payment for the dental services at the time of the visit, regardless of dental benefits.
- For our families with insurance coverage, we will gladly assist in processing your claims. Co-payment, if applicable, is expected at the time of your visit.
- Your level of insurance coverage is determined by the policy your employer selects. If you think your coverage is insufficient, you may wish to address this with your employer.
- For our patients without dental insurance, we require 50% of the total fee at the start of treatment. The balance will be due upon the completion of work.
- Our time is valuable, as is yours. We expect the courtesy of at least 24 hours notice if you cannot keep a scheduled appointment. A deposit may be taken to hold your appointment time.

We are looking forward to taking care of your child/children. We are committed to providing excellent dental care, and we welcome any suggestions or comments for the office.

I certify that I have read and understand the above questions and policies. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold Rockland Pediatric Dental and Orthodontics or any member of the staff responsible for any errors or omissions that I have made in the completion of this form.

Signature of Parent/Guardian _____ Date _____

Reviewed by _____

AUTHORIZATION

I authorize Rockland Pediatric Dental and Orthodontics to perform an oral examination for the purpose of diagnosis and treatment planning on my child. In addition, if medically necessary, I authorize the release of any information acquired in the course of this examination and treatment.

Signature of Parent/Guardian _____ Date _____

MEDICAL HISTORY

Name of physician or pediatrician _____

Address and Phone Number _____

Date of last physical examination _____ General Health: Excellent _____ Good _____ Fair _____ Poor _____

Is child under physician's care at present? _____ If yes, explain: _____

Is your child taking any medications? _____ Special diets? _____ If yes, please list: _____

Is your child allergic to any drugs, i.e. penicillin? _____ If yes, name: _____

Does your child have any allergies, i.e. eggs, latex? _____ Please list: _____

Has your child ever been hospitalized? _____ If yes, explain: _____

Is your child excessively nervous or apprehensive? _____

Has your child's development been normal? _____ Was pregnancy normal? _____ Was delivery normal? _____

Early feeding habits: Breast fed? _____ Bottle fed? _____ Formula used? _____ Type of nipple used? _____

Was a pacifier used? _____ Started and stopped at what age? _____ to _____

Child's appetite is: Excellent _____ Good _____ Fair _____ Poor _____

Child's sleep habits: Excellent _____ Good _____ Fair _____ Poor _____

DENTAL HISTORY

Reason for this visit? (First examination, check-up, toothache, etc.) _____

Do you desire complete, thorough dental care for your child? _____

Was your child's last dental experience pleasant? _____ If unpleasant, how did he/she react? _____

Did teeth erupt early or late? _____ At what age? _____

Is your child taking fluoride tablets or drops? _____ Vitamins? _____ By Prescription? _____

When was your child's last dental visit? _____

When were your child's last full mouth x-rays taken? _____

Has your child ever had: Dental X-rays Cleaning Fillings Fluoride treatment Pulpotomy/root canal
 Stainless steel crowns Extractions Surgery Gas (sweet air)
 Local anesthesia (Novocaine) Space maintainer Orthodontic appliance Sealants

Does your child have: Blows or injuries to teeth or face Sensitive teeth Bleeding or sore gums
 Unusual speech habits Missing teeth Many cavities
 Growth or sore spots in or around the mouth Extra teeth

Does your child: Grind teeth (if yes, when?) _____ Suck thumb or finger
 Bite lip or other biting habits Mouth breather

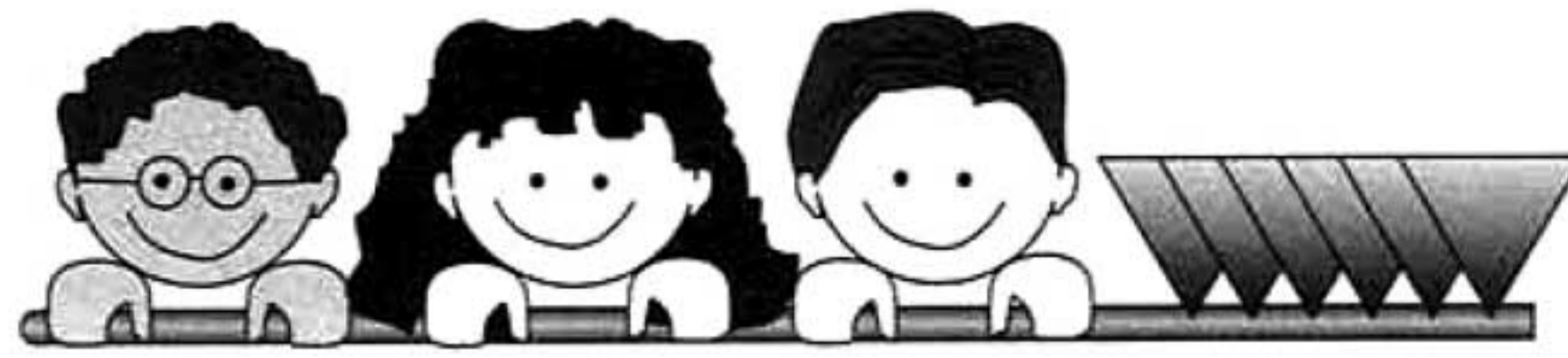
Have you ever been counseled on proper diet? _____ Instructed in proper home care of the mouth? _____

How often does your child brush his/her teeth? _____ Do you assist? _____ Type of brush? _____

Other oral hygiene aids _____

What do you believe is the cause for tooth decay in anyone?

Soft Teeth/Heredity Excessive Sweets Toothbrushing Habits Other _____



Rockland Pediatric Dental and Orthodontics

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

* You May Refuse To Sign This Acknowledgement *

I, _____, have received a copy of this office's Notice of Privacy Practices.

(Please Print Name)

(Signature)

(Date)

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify below)