Grosman
Pediatric Dentistry & Orthodontics

Today's Date: _____

Patient Information								
Last Name	**First Name**	**MI**	**Sex (M/F)**	**Date of Birth**	**Age**	**School**	**Grade**	**Hobbies/Sports**

Who is Accompanying Your Child Today? Name/Relation: _____

Parent's Marital Status (circle one that best applies): Single Widowed Separated Married Divorced

Person Responsible For Account

Name: _____ Relation: _____

BILLING ADDRESS:_____
Street City State Zip

BEST NUMBER TO CONFIRM APPOINTMENTS: _____

Guardian #1 Name: _____ _____
Last First Occupation

DOB: _____ Employer: _____ Home #: _____
Cell #: _____ Work #: _____ E-mail: _____
SS#_____ DRIVERS LICENSE# _____

Guardian #2 Name: _____ _____
Last First Occupation

DOB: _____ Employer: _____ Home #: _____
Cell #: _____ Work #: _____ E-mail: _____
SS# _____ DRIVERS LICENSE # _____

Insurance Information

Insured's Name: _____ Insurance Co.:_____
ID # FOR INS _____ Insured's Employer: _____

Whom may we Thank for referring you? _____

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and that it is my responsibility to inform this office of any changes to my child's medical status. This office reserves the right to verify the credit status of potential patients and/or parents of patients prior to extending credit for treatment fees and may at the discretion of this office, use the services of one or more credit reporting services.

I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____ _____
Signature of Parent/Guardian Relationship to Patient Date

*** The Parent or Guardian who accompanies the child is responsible for payment. ***

I have reviewed the health questionnaire with the child's parent/guardian.

_____
Signature of Dentist Date

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OFFICE FINANCIAL POLICIES

Patient Name:_____

Responsible Party: _____ **Relationship to Patient:** _____

The adult accompanying the patient is considered the responsible party for the services billed. Our office does not engage in disputes or arrangements between divorced &/or separated parents. At Grosman Pediatric Dentistry & Orthodontics we strive to provide your child with the best dental health care. In addition, we want to keep your insurance and other financial arrangements as simple as possible. Therefore, we kindly request that you adhere to the following guidelines. Please initial on each line.

- _____ It is your responsibility to provide us with your current address, telephone number and insurance information at each visit. If you do not have proof of current insurance at your visit, you will be considered a self-pay patient for that visit and payment will be due in its entirety that day.
- _____ All payments are due at the time services are rendered. We accept VISA, MASTERCARD, AMERICAN EXPRESS, DISCOVER, CASH & CHECKS. Any check dishonored by your bank may result in a $35 returned check charge being added to your account and your account going into a cash only payment basis.
- _____ It is your responsibility to contact your insurance carrier to confirm that our doctors are providers for your insurance and you understand your insurance benefits and requirements.
- _____ If we are not providers for your insurance, you will be responsible for the entire balance at the time services are rendered. We will be more than happy to provide you with a form to file the claim with your insurance carrier.
- _____ If you miss your appointment &/or cancel your appointment less than 24 hours **(less than 48 hours on NON-SCHOOL days)**, you may be charged a " BROKEN APPOINTMENT " fee of $30 (recall=cleanings)or $60 (restorative=fillings) for that type of appointment.
- _____ If you are more than 10 minutes late to your dental appointment, please contact our office. Depending on the type of appointments, some may have to be rearranged or rescheduled.
- _____ All requests for copies of dental records must be in writing and received in our office 14 days prior to the date needed. Please note there is a fee for transfer or copies of records. Records will only be mailed, not faxed.
- _____ We allow 45 days from the billing date of your insurance company to process and make payment on our claim. If we have not received any form or remittance from your insurance within the time frame specified, we will ask that you cover the outstanding balance (to avoid a finance charge of 1% per month) or contact your insurance for their delay in payment.

If you have any questions, concerns or would like to get an estimation of benefits for the services to be rendered, please feel free to contact our office manager at 954-236-3434. Thank you.

RESPONSIBLE PARTY SIGNATURE: _____ **DATE:** _____

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Consent for Dental Treatment

It is your right, as a parent, to understand the risks, benefits, and alternatives of your child's dental treatment before giving consent for specific dental treatment. By consenting to treatment, you are acknowledging your willingness to accept known risks and complications, no matter how slight the probability of occurrence.

It is very important that you provide us with accurate information before, during, and after treatment. It is equally important that you follow the dentist's advice and recommendations regarding medication, pre and post treatment instructions, referrals to other dentists or specialists, and return for scheduled appointments. If you fail to follow the advice of your dentist, you may increase the chances of a poor outcome.

Please read the items below and sign at the bottom of the form.

1. **Patient Management Techniques**

   We make every effort to maintain the cooperation of young patients using warmth, humor, friendliness, persuasion, gentleness, love, and positive reinforcement. For your child's first visit, we encourage you to accompany him/her to the hygiene/ open bay so you will be familiar with our office and the staff providing care for your child. At follow up visits where your child may need restorative care, we know that many children tend to get anxious. **This is why we ask that you allow your child to come into their appointment room without you. We find one-on-one communication to be most effective in gaining rapport and trust with your child.** There are occasions where additional behavior management may be required to gain cooperation and prevent children from injuring themselves or dental staff. The following is a list of the behavior management techniques that are recommended by the *American Academy of Pediatric Dentistry.*

   a. **Tell-show-do:** The dentist or assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstrating with instruments. The procedure is then performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.
   b. **Positive reinforcement:** This technique rewards the child who displays any behavior that is desirable. Examples of rewards include compliments, encouragement, praises, or prizes.
   c. **Voice Control:** The attention of a disruptive child is gained through lowering or raising the tone and volume of the dentist's voice. Care is taken not to make the child feel threatened. Content of the conversation is less important than the manner in which it is communicated.
   d. **Nitrous Oxide "laughing gas":** Indicated for children who are anxious. It is not intended to put children to sleep, but only to relax them and minimize their anxiety. *Nitrous oxide is only used with additional verbal and written parental consent.*
   e. **Mouth Props "tooth pillow":** A soft, rubber device used to assist the child in keeping their mouth open during a procedure.

f. **Protective stabilization by the dental assistant** -- only used if absolutely necessary. The assistant gently protects the child from movement by holding the child's hands, stabilizing the child's head or positioning the child safely in the dental chair.

2. **Treatment to be Provided** - *At the first visit, only preventive services* (exam, cleaning, fluoride, radiographs, sealants*) may be completed unless otherwise directed by you*. During the full course of treatment the following care may be provided as needed: examinations, preventive services (cleanings, radiographs, fluoride application, sealants, space maintenance), crowns, restorations, nerve treatments, extractions.
3. **Possible Risks associated with Dental Procedures-** Although good results are expected, some risks are known to be associated with dental procedures. These risks include but are not limited to: hyperventilation, fainting, development of a temporomandibular joint (TMJ) disorder, temporary or permanent numbness, pain, bleeding, swelling, tooth discoloration, nausea, vomiting, and allergic reactions.
4. **Drugs and Medications** - I understand that antibiotics, analgesics, and other medications can cause allergic reactions causing redness and swelling of tissues; pain, itching, vomiting, and/or anaphylactic shock (severe allergic reaction).
5. **Changes in Treatment Plan** - I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination. I give my permission to the dentist to make any/all changes and additions as necessary.
6. **Access to Medical Information –** I authorize Grosman Pediatric Dentistry & Orthodontics to release treatment information to my insurance company, third party payer, or other treating professionals in order to facilitate the provision of continuing healthcare. I acknowledge I have been given the opportunity to read and/or receive the health information privacy practices.

I understand all of the aforementioned and hereby acknowledge that I understand the risks, benefits, and alternatives of my child's dental treatment. I have had all my questions answered and I realize I can always seek further information or revoke permission for any of these techniques. By signing this consent once, it shall be in effect for every future dental appointment at this office, although treatment may change/be added. I further understand that this consent shall remain in effect until terminated by me in writing.

Signature Date

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CONFIRMATION OF APPOINTMENTS

The benefits of regular confirmation allows the office to maintain an on time schedule, to staff appropriately and to serve as a reminder for you about your child's upcoming appointments. In an effort to do so more successfully, **we ask that you check below your preferred method of confirmation**.

Electronic confirmation (Texts or E-Mail) is the most effective means of accomplishing this. If you choose electronic confirmation, we ask that you please respond immediately (the same day) as this will prevent you from receiving additional calls from our office and will safeguard your appointment from being cancelled.

ALL APPOINTMENTS MUST BE CONFIRMED AT LEAST 24 HOURS PRIOR TO AVOID THEM BEING CANCELLED. THANK YOU FOR YOUR UNDERSTANDING.

I PREFER TO BE CONFIRMED BY THE FOLLOWING METHOD **(please check off one):**

1) **TEXT**
   Cell Number: _____

2) **E-MAIL**
   E-mail address: _____

3) PHONE CALL = Best Number: _____

SIGNATURE _____ DATE _____

Pediatric Medical History

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Child's Full Name			Nickname	Date of Birth
Gender ☐ M ☐ F	Race/Ethnicity	Height	Weight	Date of last physical examination

Name/address/phone of primary physician

Name/address/phone of medical specialist

	Yes	No
Is your child being treated by a physician at this time? Reason _____	☐	☐
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplement?	☐	☐
List name, dose, frequency & date started _____		
Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department?	☐	☐
List date & describe _____		
Has your child ever had a reaction to or problem with an anesthetic? Describe _____	☐	☐
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List _____	☐	☐
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List _____	☐	☐
Is your child up to date on immunizations against childhood diseases?	☐	☐

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of those conditions applies to your child.

		Yes	No
1.	Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions	1. ☐	☐
2.	Problems with physical growth or development	2. ☐	☐
3.	Sinusitis, chronic adenoid/tonsil infections	3. ☐	☐
4.	Sleep apnea/snoring, mouth breathing, or excessive gagging	4. ☐	☐
5.	Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease	5. ☐	☐
6.	Irregular heart beat or high blood pressure	6. ☐	☐
7.	Asthma, reactive airway disease, wheezing, or breathing problems	7. ☐	☐
8.	Cystic fibrosis	8. ☐	☐
9.	Frequent colds or coughs, or pneumonia	9. ☐	☐
10.	Frequent exposure to tobacco smoke	10. ☐	☐
11.	Jaundice, hepatitis, or liver problems	11. ☐	☐
12.	Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems	12. ☐	☐
13.	Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions	13. ☐	☐
14.	Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder	14. ☐	☐
15.	Bladder or kidney problems	15. ☐	☐
16.	Arthritis, scoliosis, limited use of arms or legs, or muscle/bone/joint problems	16. ☐	☐
17.	Rash/hives, eczema or skin problems	17. ☐	☐
18.	Impaired vision, hearing, or speech	18. ☐	☐
19.	Developmental disorders, learning problems/delays, or intellectual disability	19. ☐	☐
20.	Cerebral palsy, brain injury, epilepsy, or convulsions/seizures	20. ☐	☐
21.	Autism/autism spectrum disorder	21. ☐	☐
22.	Recurrent or frequent headaches/migraines, fainting, or dizziness	22. ☐	☐
23.	Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous)	23. ☐	☐
24.	Attention deficit/hyperactivity disorder (ADD/ADHD)	24. ☐	☐
25.	Behavioral, emotional, communication, or psychiatric problems/treatment	25. ☐	☐
26.	Abuse (physical, psychological, emotional, or sexual) or neglect	26. ☐	☐
27.	Diabetes, hyperglycemia, or hypoglycemia	27. ☐	☐
28.	Precocious puberty or hormonal problems	28. ☐	☐
29.	Thyroid or pituitary problems	29. ☐	☐
30.	Anemia, sickle cell disease/trait, or blood disorder	30. ☐	☐
31.	Hemophilia, bruising easily, or excessive bleeding	31. ☐	☐
32.	Transfusions or receiving blood products	32. ☐	☐
33.	Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant	33. ☐	☐
34.	Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS	34. ☐	☐

Provide details here: _____

Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told? ..... Yes ☐ No ☐

If YES, describe _____

What is your primary concern about your child's oral health? _____

How would you describe: Your child's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Your oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

The oral health of your other children? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Is there a family history of cavities? ☐ YES ☐ NO If yes, indicate all that apply: ☐ Mother ☐ Father ☐ Brother ☐ Sister

Does your child have a history of any of the following? For each marked, please describe:

☐ Inherited dental characteristics
☐ Mouth sores or fever blisters
☐ Bad breath
☐ Bleeding gums
☐ Cavities/decayed teeth
☐ Toothache
☐ Injury to teeth, mouth or jaws
☐ Clinching/grinding his/her teeth
☐ Jaw joint problems (popping, etc.)
☐ Excessive gagging
☐ Sucking habit after one year of age
Which: ☐ Finger ☐ Thumb ☐ Pacifier ☐ Other
For how long? _____

Provide details here: _____

How often does your child brush his/her teeth? _____ times per _____ Does someone help your child brush? ☐ YES ☐ NO

How often does your child floss his/her teeth? ☐ Never ☐ Occasionally ☐ Daily Does someone help your child floss? ☐ YES ☐ NO

What type of toothbrush does your child use? ☐ Hard ☐ Medium ☐ Soft ☐ Unsure What toothpaste does your child use? _____

What is the source of your drinking water at home? ☐ City/community supply ☐ Private well ☐ Bottled water

Do you use a water filter at home? ☐ YES ☐ NO If YES, type of filtering system: _____

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Please check all sources of fluoride your child receives:
☐ Drinking water ☐ Toothpaste ☐ Over-the-counter rinse ☐ Prescription rinse/gel ☐ Prescription drops/tablets/vitamins
☐ Fluoride treatment in the dental office ☐ Fluoride varnish by pediatrician/other practitioner ☐ Other: _____
Does your child regularly eat 3 meals each day? ☐ YES ☐ NO
Is your child on a special or restricted diet? ☐ YES ☐ NO If YES, describe: _____
Is your child a 'picky eater'? ☐ YES ☐ NO If YES, describe: _____
Does your child have a diet high in sugars or starches? ☐ YES ☐ NO If YES, describe: _____
Do you have any concerns regarding your child's weight? ☐ YES ☐ NO If YES, describe: _____
How frequently does your child have the following?
Candy or other sweets ☐ Rarely ☐ 1-2 times/day ☐ 3 or more times/day Product _____
Chewing gum ☐ Rarely ☐ 1-2 times/day ☐ 3 or more times/day Type _____
Snacks between meals ☐ Rarely ☐ 1-2 times/day ☐ 3 or more times/day Usual snack _____
Soft drinks* ☐ Rarely ☐ 1-2 times/day ☐ 3 or more times/day Product _____
(*Such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)
Please note other significant dietary habits: _____
Does your child participate in any sports or similar activities? ☐ YES ☐ NO If YES, list: _____
Does your child wear a mouth guard during these activities? ☐ YES ☐ NO If YES, type: _____
Has your child been examined or treated by another dentist? ☐ YES ☐ NO If YES: Date of first visit: _____ Date of last visit: _____ Reason: _____
Were x-rays taken of the teeth or jaws? ☐ YES ☐ NO Date of most recent dental x-rays: _____
Has your child ever had orthodontic treatment (braces, spacers, or other appliances)? ☐ YES ☐ NO If YES, when? _____
Has your child ever had a difficult dental appointment? ☐ YES ☐ NO If YES, describe: _____
How do you expect your child will respond to dental treatment? ☐ Very well ☐ Fairly well ☐ Somewhat poorly ☐ Very poorly
Is there anything else we should know before treating your child? ☐ YES ☐ NO
If yes, describe: _____

Signature of parent/guardian	Relationship to child	Date	Signature of staff member reviewing history

MEDICAL/DENTAL HISTORY UPDATE

	Yes	No
Is your child being treated by a physician at this time? Reason _____	☐	☐
Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplement?	☐	☐
List name, dose, frequency & date started _____		
Has your child had any illness, surgery, injury, allergic reaction, or medical emergency in the past year?	☐	☐
Describe _____		
Has your child ever had a reaction to or problem with an anesthetic? Describe _____	☐	☐
Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List _____	☐	☐
Is your child allergic to latex or anything else such as metals, acrylic, or dye? List _____	☐	☐
Have there recently been any significant changes/disruptions to your child's family, home, or school routines?	☐	☐
Describe _____		
What is your primary concern regarding your child's oral health? _____		
Has your child had any tooth pain or injury to the mouth/teeth/jaws since last visiting our office? Describe _____	☐	☐
Has your child's diet changed significantly since his/her last dental visit? Describe: _____	☐	☐
Has your child been treated by another dentist/dental professional since last visiting our office? Reason: _____	☐	☐
Is there any other change in the child's medical, dental, or family history that the dentist should be told?	☐	☐
Describe _____		

Signature of parent/guardian	Relationship to child	Date	Signature of staff member reviewing history

SUPPLEMENTAL HISTORY QUESTIONS FOR AN INFANT/TODDLER

Was your child born prematurely? ☐ YES ☐ NO If YES, what week? _____
What was your child's birth weight? _____ How long was your child breast-fed? _____ How long was your child bottle-fed? _____
Do/did you feed your child infant formula? ☐ YES ☐ NO If YES, what type? (Check one): ☐ Ready to use ☐ Powdered ☐ Liquid concentrate
Does/did your child sleep with a bottle? ☐ YES ☐ NO If YES, content of bottle? _____
Does/did your child use a no-spill training cup? _____ (sippy cup)? ☐ YES ☐ NO
Child's age (in months) when first tooth appeared in mouth? _____ Has your child experienced any teething problems? ☐ YES ☐ NO
When did you begin brushing his/her teeth? _____ When did you begin using toothpaste? _____
Who is your child's primary care taker during the day? _____ During the evening? _____
Name/age of siblings at home: _____

Signature of parent/guardian	Relationship to child	Date	Signature of staff member reviewing history

SUPPLEMENTAL HISTORY QUESTIONS FOR AN ADOLESCENT PATIENT (to be completed by the patient)

Do you have any concerns about your mouth, teeth,or oral health? ☐ YES ☐ NO If YES, please describe _____
Have you recently experienced any dental/oral pain? ☐ YES ☐ NO If YES, describe: _____
Do you have any concerns with the appearance of your teeth or smile? ☐ YES ☐ NO If YES, describe: _____
Do you bleach your teeth? ☐ YES ☐ NO If YES, how often: _____
Have there been any recent changes in your dietary habits? ☐ YES ☐ NO If YES, describe: _____
Are you taking any dietary or herbal supplements? ☐ YES ☐ NO If YES, describe: _____
Do you participate in contact sports or high speed sports (skiing, motorcycles)? ☐ YES ☐ NO If YES, describe: _____

Signature of patient	Date	Signature of staff member reviewing history

We recognize that patients may engage in certain behaviors/activities that can have significant consequences on their oral health and/or general health. In addition, medicines that we use to treat oral conditions may interact with drugs (prescription, over-the-counter, or recreational) and other substances a patient might be using. Therefore, we encourage our adolescent patients to answer all of the following questions truthfully. If you prefer not to answer an item, we hope you will discuss any concerns confidentially with your dentist.

Do you have any history of (mark with an X):
☐ Oral habits (chewing fingernails, clenching/grinding teeth, etc.)
☐ Tobacco use (cigarette, pipe, cigar, bidi, snuff, spit, chew, etc.)
☐ Eating disorder (anorexia, bulimia, etc.)
☐ Oral piercing/jewelry (including grill)
☐ Alcohol or recreational drug use/prescription abuse
☐ Inhalant use/abuse (such as huffing)
☐ Sexual activity (including oral sex)
Females: Are you pregnant or possibly pregnant? ☐ YES ☐ NO
Is there anything you would like to discuss confidentially with your dentist? ☐ YES ☐ NO
Would you like to discuss a referral to a family dentist or general dentist because of your age? ☐ YES ☐ NO

Signature of patient	Date	Signature of staff member reviewing history