



Brooklyn  
**PEDIATRIC DENTISTRY**

To provide the safest and most comprehensive dental care for your child,  
we ask for your cooperation in completing our detailed questionnaire.

Child's name: \_\_\_\_\_ DOB: \_\_\_\_\_ Gender: M / F

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Address: \_\_\_\_\_ Apt. #: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code: \_\_\_\_\_

Physician's Name: \_\_\_\_\_ Physician's Phone: \_\_\_\_\_

Pharmacy: \_\_\_\_\_ Pharmacy Phone: \_\_\_\_\_

Who can we thank for referring you to our office? \_\_\_\_\_

Child primarily lives with: \_\_\_\_\_ Relationship to child: \_\_\_\_\_

Is your child presently under the care of a physician for any reason? Yes No

If yes, explain: \_\_\_\_\_

### Treatment Consent

**The permission of a parent or legal guardian is necessary for dental treatment of a minor.** As a minor child, it is necessary that a signed permission be obtained from a parent or legal guardian before any dental care can begin. As a parent or legal guardian of the above patient, I acknowledge that the above information is correct and grant "Marlboro Pediatric Dentistry" permission to provide my child's dental and related medical/surgical treatment as deemed necessary, including digital radiographs (x-rays), diagnostic, restorative, oral surgery, and patient management techniques that are reasonable, necessary and advisable. Protective restraints are used when a child might harm themselves or when certain procedures may jeopardize their health and welfare without such restraints. I also authorize the administration of anesthetics or analgesics that are advisable by *Dr. Yana*, such as nitrous oxide (laughing gas).

I have given an accurate report of this patient's physical and mental health history. I have also reported any prior allergic or unusual reactions to medications, latex, foods, or metals, and any other disease or condition, including pregnancy.

I agree to inform Dr. Yana and the staff of "Marlboro Pediatric Dentistry" of any changes in the medical history. This authorization is valid until revoked by me in writing.

SIGNATURE

RELATIONSHIP TO CHILD

DATE

# INSURANCE INFORMATION

Primary

Insurance company name: \_\_\_\_\_ Group#: \_\_\_\_\_ ID#: \_\_\_\_\_

Policy owners name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Employer: \_\_\_\_\_

Secondary (If applicable)

Insurance company name: \_\_\_\_\_ Group#: \_\_\_\_\_ ID#: \_\_\_\_\_

Policy owners name: \_\_\_\_\_ DOB: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship to child: \_\_\_\_\_ Employer: \_\_\_\_\_

We value your busy schedule and strive to see patients at their scheduled appointment times: We ask you to extend the same courtesy. Whenever possible please provide a minimum of 24 hours advance notice when requesting a scheduling change so that we can arrange care for our other patients experiencing urgent dental needs.

# MEDICAL HISTORY

If your child has or ever had any of the following conditions, please check "Yes" below. Please explain any conditions to the doctor.

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Y	N	Condition	Y	N	Condition
		ADD/ADHD			Hearing impairment
		Aids/HIV			Heart disease
		Asthma			Heart Murmur
		Autism			Hemophilia
		Behavioral Problems			Hepatitis/Liver disease
		Birth Defects			High blood pressure
		Bleeding Gums			Kidney disease
		Blood transfusions			Mentally Handicapped
		Bone/Joint problems			Metallic implant/Shunts
		Brain injury			Pins/Rods
		Cerebral palsy			Premature birth
		Cancer/Tumor			Prolonged bleeding when cut
		Chemical dependency			Psychiatric care
		Chemotherapy/radiation			Rheumatic fever
		Chicken Pox			Sickle cell disease
		Child abuse			Sore Throats
		Cleft palate/lip			Speech Impairment
		Cold sores/Canker sores			Surgery of any kind (specify) _____
		Developmentally delayed (age level): ____			Thyroid Disease
		Diabetes			Tonsillitis
		Earaches/Ear Infections			Transplants, Organ (specify) _____
		Epilepsy/Seizure disorder			Tuberculosis
		Eye conditions			Other (specify) _____

Does your child have any allergies to medicines, latex, foods, or metals?  Yes  No

Explain: \_\_\_\_\_

List all medication, supplements and vitamins your child currently takes

\_\_\_\_\_

Physician Signature: \_\_\_\_\_

## Dental History

Is this your child's first dental visit?  Yes  No

Previous Dentist: \_\_\_\_\_ Phone number: \_\_\_\_\_

Date of last visit: \_\_\_\_\_ Date of last x-rays: \_\_\_\_\_

Has your child experienced any unfavorable reaction from previous dental or medical care?

Yes  No Explain: \_\_\_\_\_

How often does your child brush? \_\_\_\_\_

Is Fluoride Toothpaste used?  Yes  No Is dental floss used?  Yes  No

Is brushing supervised?  Yes  No Does a parent do the brushing?  Yes  No

Does your child receive (check all that apply):

Tap water  Well water  Bottled water  Fluoride rinse  Fluoride tablets/drops

Has there been any injuries to your child's teeth or jaws?  Yes  No

Explain: \_\_\_\_\_

History of (check all that apply): Circle those that are ongoing currently.

Breast feeding  Thumb sucking  Bottle habits  Pacifier

Sippy cup  Teeth grinding/clenching

Has your child experienced recent dental pain?  Yes  No

Explain: \_\_\_\_\_

Does your child have a specific dental problem that needs attention?  Yes  No

Describe: \_\_\_\_\_

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have received or been offered a copy of this office's  
Notice of Privacy Practices.

Please print name: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

## Financial Policy

**If you have insurance**, we will do all we can to maximize your benefit. Dental Insurance is a contract between you, your employer, and your insurance carrier. Your dental insurance is not a contract between your insurance carrier and your doctor, unless your doctor is a provider for your insurance carrier and has contracted to a specific fee schedule with your carrier. The estimated payment for the primary policy will be due at the time of service.

On treatment visits, we are usually able to accept your insurance if you obtain prior approval from our office. If we accept your insurance, we will have you pay your estimated portion not covered by insurance (we will determine for you). If your insurance pays more than your account balance, we will send you a refund immediately.

No procedure performed on the human body can be guaranteed, as such payment is due and fees are non-refundable regardless of treatment outcome.

**NON-INSURED PATIENTS:** All fees are payable on the day service are rendered.

**Please circle your method of payment:** Check    Cash    Visa    MasterCard    Discover    Amex

**Financial Agreement:** I have read understand, and agree to the financial policy set forth by Marlboro Pediatric Dentistry. I understand that this office has not contracted with any insurance company and will file my insurance as a courtesy. I understand that insurance benefits given at the time of service are only estimates and that I am responsible for the payment of this account. I understand that as soon as my insurance carrier issues a payment, or after 60 days, any unpaid portion of my claim will be due. I authorize my insurance carrier to issue benefits directly to this office and also the release of any information necessary to process the dental insurance. If the use of a third party becomes necessary to secure payment, I agree to be responsible for any and all collection charges incurred, which includes 35% of my outstanding balance and cost of collections, which include court costs and attorney fees.

**Parent/ Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_