Pediatric Dentistry
Rockland A. Ray, D.D.S.

PATIENT INFORMATION

Date: _____
Patient Name: _____ Nickname: _____
Age: _____ Birth Date: _____ ☐Male ☐Female
Patient lives with: ☐Both parents ☐Mother ☐Father ☐Other: _____
Names and ages of siblings:
_____
_____
Child's school: _____
How were you referred to our office? (Please check and explain) ☐Our website ☐Insurance ☐Friend/relative ☐Previous patient ☐Doctor _____

PARENT/GUARDIAN INFORMATION

☐Father ☐Stepfather ☐Guardian
Name: _____ DOB: _____ SSN: _____
Home address: _____ City: _____ Zip: _____
Home phone: _____ Cell phone: _____
Employer: _____ Work phone: _____
E-mail: _____ *we may contact you through email
☐Mother ☐Stepmother ☐Guardian
Name: _____ DOB: _____ SSN: _____
Home address: _____ City: _____ Zip: _____
Home phone: _____ Cell phone: _____
Employer: _____ Work phone: _____
E-mail: _____ *we may contact you through email

Parent's marital status: _____ Preferred Salutation: ☐Mr. ☐Mrs. ☐Ms. ☐Dr.
Emergency contact name: _____ Phone#: _____

INSURANCE INFORAMTION

Does your child have dental insurance coverage? ☐No ☐Yes
Policy Holder: _____ Relationship to patient: _____
Home address: _____ City: _____ Zip: _____
Insured's SSN: _____ Birthdate: _____ Employer: _____
Insurance Company: _____ Phone #: _____
Policy ID: _____ Group #: _____
Dental claims address: _____

MEDICAL HISTORY

1) Patient's Pediatrician: _____ Phone #: _____
2) Is your child being seen by a physician for something other than routine care?
   ☐No ☐Yes (explain) _____
3) Mark if your child has any of the following and explain.
   - ☐ Heart Murmur
   - ☐ Congenital Heart disease
   - ☐ Asthma, cystic fibrosis, respiratory disease
   - ☐ Jaundice, Hepatitis, Liver disease
   - ☐ Diabetes, thyroid, endocrine disease
   - ☐ Kidney disease
   - ☐ Seizures, cerebral palsy, neurological disease
   - ☐ HIV, sexually transmitted diseases
   - ☐ Anemia, hemophilia, bleeding disorder
   - ☐ Sickle cell disease or traits
   - ☐ Cancer
   - ☐ Speech or hearing
   - ☐ Sight or eye disorder
   - ☐ Received blood or blood products

   (Explain) _____
4) Does your child have any other medical conditions we should be aware of?
   ☐No ☐Yes (explain) _____
5) Has your child been seriously ill or hospitalized?
   ☐No ☐Yes (explain) _____
6) Has your child ever had surgery?
   ☐No ☐Yes (explain) _____
7) Does your child take any medications?
   ☐No ☐Yes (explain) _____
8) Does your child have any developmental or behavior problems?
   ☐No ☐Yes (explain) _____
9) Mark if your child is allergic to any of the following:
   ☐ Penicillin/antibiotics ☐ Local anesthesia ☐ Codeine/narcotics
   Please list other allergies: _____
10) Has your child done any of the following (past or present)?
   ☐Thumb/finger-sucking ☐pacifier ☐nail biting ☐mouth-breathing ☐teeth grinding ☐ other
   (Explain) _____

DENTAL HISTORY

1) Is this your child's first dental visit? ☐No ☐Yes If no, previous dentist: _____
2) Date of last visit: _____ Were any x-rays taken? ☐No ☐Yes
3) How was his/her experience? _____
4) Attitude towards the dentist or dental care: _____
5) Has your child had any injuries to teeth, mouth, or head?
   ☐No ☐Yes (explain) _____
6) Is your water fluoridated? ☐No ☐Yes ☐Unsure
7) Does your child use fluoridated toothpaste? ☐No ☐Yes (explain) _____
8) Are supplemental fluorides used at home? ☐No ☐Yes (explain) _____
9) How often does your child brush his/her teeth? _____
10) Does your child brush with adult supervision? ☐No ☐Yes (explain) _____

NON-PARENT/GUARDIAN AURTHORIZATION

I, _____ give my consent to allow person(s) named below other than myself to accompany and oversee my child for appointments, to release healthcare information for the appointment or to secure payment for dental services. I understand I can revoke this consent at any time by providing written notice. Persons who have consent in my absence are:

1) _____ Relation: _____
2) _____ Relation: _____

_____ _____
Signature of Parent/Guardian Date

CONSENT

1) Because your child is a minor, it is necessary that a signed permission is obtained from a parent or legal guardian before Dr. Rockland Ray or his staff can begin treatment.
2) Your child's specific treatment concerns will be explained to you after the examination and prior to any treatment. We will also review the treatment performed after each visit.
3) Our examination may include dental radiographs (x-rays) depending on your child's specific needs. Photographs may be taken for diagnosis and treatment.
4) Local anesthesia and nitrous oxide (laughing gas) can be used to facilitate your child's comfort during dental treatment. The use of these medications will be explained to you prior to beginning treatment.
5) No sedative drugs are used by Dr. Ray in the office. However, Dr. Ray performs sedation and general anesthesia procedures in a hospital setting. Should general anesthesia be deemed necessary to treat your child, you will be consulted. The procedure will be explained and a separate appointment time will be necessary.
6) Consent is hereby given for diagnostic, restorative, and surgical treatment for my child. Restorative treatment may include fillings, crowns, sealants, root canal therapy, or space maintainers. Restorative materials may include composite resin, amalgam, and stainless steel. Surgical treatment may include tooth removal and minor soft tissue treatment.

_____ _____
Signature of Parent/Guardian Date

PRACTICE FINANCIAL POLICY

1) Payment in full is expected when services are rendered, including insurance co-payments. Payments can be made by cash, check, Visa, MasterCard, and Discover. If an unexpected payment plan is required, arrangements must be made with our financial coordinator prior to treatment.
2) We are happy to help you file your insurance claim. However, because your insurance contract is between you and your insurance company, you are ultimately responsible for all charges. Any unpaid claim or amount by your insurance company will be your responsibility.
3) As a courtesy to you, we will submit your insurance claim as long as we have been provided with all of the necessary information. If the information cannot be provided, payment in full will be expected and we will provide you with a statement of services rendered**. Account balances that are more than 60 days overdue will be charged a monthly rebilling fee of $5.00.**
4) Our staff will confirm your dental appointments 24-48 hours in advance. We expect the same courtesy to be given to us when canceling your appointments. Exceptions will be considered at Dr. Ray's discretion for emergencies. **If 24 hours' notice is not given, a charge of $50.00 will be applied to each appointment that was broken that day.**

_____ _____
Signature of Parent/Guardian Date