

PEDIATRIC DENTISTRY

Thank you for choosing Arch Dental Associates for your dental care. Our primary mission is to deliver the finest and most advanced dental care available today to enable you to keep your teeth and gums healthy and beautiful throughout your lifetime.

We specialize in caring for our patients. Here at our state-of-the-art office you will experience gentle and professional care you have been looking for. Whatever your dental needs may be, we can satisfy them within the confines of our office. We are here to assist you with any questions you may have concerning any aspect of your dental treatment.

For your convenience, we have enclosed a health history form, notice of privacy practices and our financial policy. Please complete the health history form and bring it with you on your visit with us. If you have any questions or would like to discuss the financial options available to you, please feel free to call us.

We welcome you in joining our family of patients and look forward to caring for you!

FROM ALL OF US..... WELCOME!

PATIENT INFORMATION:

NAME: _____ DATE OF BIRTH: _____

HOME PHONE #: _____ CELL PHONE #: _____ WORK #: _____

ADDRESS: _____ APT. #: _____

CITY: _____ STATE: _____ ZIP CODE: _____

CHILD'S SCHOOL: _____

Who may we thank for referring you? _____

Any other family members who are patients at this office? _____

MATERNAL PARENT'S INFORMATION:

PATERNAL PARENT'S INFORMATION:

NAME: _____ NAME: _____

DATE OF BIRTH: _____ DATE OF BIRTH: _____

OCCUPATION: _____ OCCUPATION: _____

WORK PHONE #: _____ WORK PHONE #: _____

CELL PHONE #: _____ CELL PHONE #: _____

If the Patient's address is different from the Parent's Home address, Please specify below:

Patient's Name: _____

Address: _____ Apt.#: _____

City: _____ State: _____ Zip Code: _____

Who will be responsible for payment of dental treatment? _____

DENTAL HISTORY:

How many times a day does your child Brush? _____

Does your child floss Y N

Which of the following symptoms apply if any?

Spots / growths	Y	N	Frequent Sore throats	Y	N
Cold sore	Y	N	Bad Breath	Y	N
Bleeding/ sore gums	Y	N	Grinding	Y	N
Mouth breathing	Y	N	Speech Problems	Y	N
			Abscess	Y	N

Is your child having any dental discomfort? Y No

If yes please explain: _____

Has your child ever had previous dental treatment? Y N

If yes please explain: _____

Has your child ever had any trauma or injuries to teeth or face? Y N

If yes please explain: _____

Has your child ever had any orthodontic treatment? Y N

Does your child behave with the pediatrician? _____

Does your child have any oral habits? Y N

Finger/thumb habit	Y	N	Breastfeeding	Y	N
Pacifier	Y	N			

Is your child using a bottle? Y N If yes, contents: _____

If not, at what age was the bottle/breastfeeding discontinued: _____

Does your child drink bottled or NYC water? Y N

Does your child take vitamins supplemented with fluoride? Y N

MEDICAL HISTORY:

Date of last Check up: ____/____/____

Name of Pediatrician: _____ Phone # _____

Address: _____ Suite# _____

City: _____ State: _____ Zip Code: _____

Has your child ever had any of the following?

Visual Disorder	Y	N	Hearing disorder	Y	N
Rheumatoid Arthritis	Y	N	Anemia	Y	N
Ear Infections	Y	N	Prolonged Bleeding	Y	N

For your convenience, you may elect to keep a credit card on file with our office.

___ I do not authorize any credit cards to be on file.

___ I hereby authorize *Arch Dental Associates* to keep my credit card on file, in which it could be used to charge for any visits, as well as to clear any balances on my account. We will mail you a statement with a copy of your credit card receipt.

Card Type: _____

CC#: _____ Exp. Date: _____ Billing Zip Code: _____

Cardholder's Name: _____ Signature: _____

*All return checks are subject to a twenty-five dollar service charge.

▪ **CONSENT FOR TREATMENT**

I hereby consent to the dental procedures and techniques including but not limited to the use of physical restraint or restraining devices to safely accomplish the necessary dental procedures which, Shantanu Lal DDS., and Arch Dental Associates deem necessary for the treatment. I authorize the dentist to provide any information to the other doctors for the purpose of consultation. I understand that prior to any treatment, I will be advised about the proposed by the dentist or hygienist and 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.

Signature: _____ Date: _____

Reviewed By: _____ D.D.S., D.M.D., R.D.H. Date: _____

□ **CONSENT FOR N2O SEDATION**

A written and verbal explanation for the use of nitrous oxide minimal sedation has been provided to me. I understand and authorize such use for the treatment of my child.

Signature: _____ Date: _____

Reviewed By: _____ D.D.S., D.M.D., R.D.H. Date: _____

□ **CONSENT FOR AUTHORIZATION FOR A DESIGNATED ADULT TO CONSENT FOR AND ACCOMPANY A MINOR PATIENT**

I, _____, the father/mother/legal guardian of _____
(name of the parent or guardian) (name of child patient)

authorize _____ to accompany my child (or legal ward for
(adult 18 years or older who will accompany child)

whom I am empowered to consent); to give consent for any necessary dental procedures. This authorization will remain in effect until such time as I give notice of its termination.

❑ **CONSENT FOR USE OF PHYSICAL RESTRAINT**

A written and verbal explanation for the use of physical restraint has been provided to me. I understand and authorize such use for the treatment of my child.

**BY SIGNING BELOW, I UNDERSTAND AND AGREE TO THIS POLICY ALL ASPECTS OF
DENTAL TREATMENT NEEDED FOR MY CHILD**

NAME: _____ SIGNATURE: _____