Welcome!

Upper East

Pediatric Dentistry

30 East 60th Street, Suite 608
New York, NY 10022
212.317.1212
uppereastpediatric@gmail.com

Welcome to our practice! Our staff will do whatever we can to make this dental experience pleasant for you and your child. Please complete this form thoroughly; information is essential to help us better understand your child.

Basic information

Child's Name:_____Nickname: _____Sex: M or F

DOB:_____Age_____ Place of Birth_____ Current school: _____Grade:_____

Name(s) and age(s) of brother(s) & sister(s)_____

Have any other children in your family been a patient in this office before? YES or NO

- If YES, please provide names: _____

In the past, has your child had any bad dental or medical experiences? YES or NO

- If YES, please explain:_____

Please check any of the following that may describe your child:

( )Outgoing ( )Shy ( )Bubbly ( )Anxious ( )Frightened ( )Defiant ( )Cranky
( )Suspicious ( )Moody ( ) High Strung ( ) Regular Kid ( )Friendly ( ) Cooperative ( )Overtired

Child's favorite interest/sport:_____ Name(s) of pet(s):_____

How do you expect your child to react to his or her visit today?

( ) Excellent, no concerns ( ) Fair, some anxiety ( ) Poorly, very fearful ( ) Uncertain/ don't know

How may we help to make this a positive experience for your child?_____

What is your specific concern today?_____

Name of family dentist:_____

Whom may we thank for referring you to our office? _____

Dental information

Yes No

( ) ( ) Is this your child's first dental visit? If no, what is the date of the most recent visit?_____

Please describe **what** was done and by **whom**?_____

( ) ( ) Was your child bottle fed? If yes, until what age?_____

( ) ( ) Was your child breast fed? If yes, until what age?_____

( ) ( ) Has your child ever had any injuries to his/her teeth, mouth, head, or jaws? If yes, describe

_____

( ) ( ) Does your child brush his/her teeth daily?

( ) ( ) Does an adult assist with the brushing? If yes, who assists?_____ __

( ) ( ) Does your child floss daily?

( ) ( ) Does an adult assist with the flossing? If yes, who assists?

Please indicate if your child has any of the following mouth habits.

( ) finger sucking ( ) thumb sucking ( ) uses a pacifier

( ) mouth breather ( ) teeth grinding

Other_____

Medical Information

Child's Pediatrician: _____ Address: _____

Phone: _____ Date of last physical: _____

Is your child in good health? Yes ( ) No ( ) Is your child adopted? Yes ( ) No ( ) Are your child's immunizations up to date? Yes ( ) No ( )

Does your child need to be pre-medicated (with antibiotics) before dental treatment? Yes ( ) No ( )

Is your child being treated for any condition presently? Yes ( ) No ( ) If so, explain. _____

Has your child ever been hospitalized or had surgery? Yes ( ) No ( ) If so, explain._____

Does your child have any allergies or reactions to any medications? Yes ( ) No ( ) If so, explain._____

Please check if your child has any of the following allergies.

Latex ( ) Pollen ( ) Food ( ) Food dyes ( ) Dust ( ) Others ( ) _____

List all medication, supplements and vitamins your child currently takes. _____

Does your child communicate verbally? Yes ( ) No ( ) Please indicate your child's developmental age. _____

Does your child currently receive or has your child ever had speech therapy? Yes ( ) No ( ) If yes, please provide dates._____

Please check **yes** or **no** for each item.	Please check **yes** or **no** for each item listed.	Please check **yes** or **no** for each item listed.
Yes No	Yes No	Yes No
( ) ( ) HIV/AIDS/Hepatitis	( ) ( ) Cleft lip/palate	( ) ( ) Kidney/Liver disease
( ) ( ) Allergies to medications	( ) ( ) Convulsions/seizures	( ) ( ) Leukemia
( ) ( ) Anemia	( ) ( ) Diabetes	( ) ( ) Nutritional deficiency
( ) ( ) Autism Spectrum	( ) ( ) Developmental delay	( ) ( ) Oral ulcers
( ) ( ) Asthma	( ) ( ) Down syndrome	( ) ( ) Orthopedic problems
( ) ( ) Autism	( ) ( ) Ear infections	( ) ( ) Premature birth
( ) ( ) Birth defects	( ) ( ) Emotional disturbances	( ) ( ) PT or OT Issues
( ) ( ) Bladder conditions	( ) ( ) Epilepsy	( ) ( ) Rheumatic fever
( ) ( ) Blood transfusion	( ) ( ) Eye problems	( ) ( ) Scoliosis
( ) ( ) Bone or joint problems	( ) ( ) Excessive bleeding	( ) ( ) Sensory Integration Issues
( ) ( ) Brain injury	( ) ( ) Excessive gagging	( ) ( ) Sickle Cell Anemia
( ) ( ) Bruising easily	( ) ( ) Fainting or dizziness	( ) ( ) Spina Bifida
( ) ( ) Cancer or Malignancies	( ) ( ) Hearing/Speech problems	( ) ( ) Syndrome_____
( ) ( ) Cerebral Palsy	( ) ( ) Heart Problems	( ) ( ) Tonsil/Adenoid Infection
( ) ( ) Child/Sexual abuse	( ) ( ) Hemophilia	( ) ( ) Tuberculosis
( ) ( ) Chronic headaches	( ) ( ) Hyperactivity	( ) ( ) Vision Issues_____

Please describe <u>any</u> current special needs, medical treatment including drugs, pending surgery, recent injuries, hospitalizations or any other evaluations your child has had _____

General Information

Does the child live with both parents? YES ( ) Father Only ( ) Mother Only ( ) Shared Custody ( ) Other ( ) _____

If the child has step-parents, please list their names here. _____

Parent #1 full name_____

Address_____

City_____ State_____ Zip code_____

Home #_____Cell#_____

E-mail address _____

DOB_____SSN_____

Occupation_____

Employer_____

Parent #2 full name_____

Address_____

City_____ State_____ Zip code_____

Home #_____Cell#_____

E-mail address _____

DOB_____SSN_____

Occupation_____

Employer_____

Who is responsible for your child's account? _____

Who is the child's legal guardian? _____

Signature of Parent or Guardian: _____ Date _____

Initials of staff member reviewing form: _____

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A LEGAL GUARDIAN FOR THE CHILD MUST COMPLETE THIS FORM.

REQUEST AND CONSENT FOR DENTAL TREATMENT

Please read this form *carefully*. If you do not understand something to your satisfaction, please ask questions. We will be pleased to explain it.

1. I request and authorize the dental treatment by Dr. Sabiya Amanat DDS and staff.

   Patient Name: _____

2. I am the legal guardian of the child named above. _____(**Initials**)

3. I further request and authorize the taking of dental x-rays and the use of such anesthetics as may be considered necessary to treat my child's dental need(s).

4. I have had explained to me by Dr. Sabiya Amanat and staff, and have had sufficient opportunity to discuss the patient's dental condition/problem(s), the planned procedures and treatment, and the benefits to be reasonably expected from this treatment plan, compared with alternative approaches and/or no treatment.

5. It is unusual for any of the following risks or complications to occur. These risks or complications include but are not limited to, the possibility of pain or discomfort during the treatment, swelling, infection, bleeding, injury to adjacent teeth and surrounding tissue, development of a temporomandibular joint disorder, temporary or permanent numbness, and allergic reactions.

6. **I understand** that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the patient's treatment plan and that I will be consulted *prior to initiation of treatment procedures* not listed. I am aware that the practice of dentistry is not an exact science and acknowledge that no guarantees have been made to me concerning the results of the dental treatment that the patient receives in our office.

7. **I understand** it is the goal of this dental office to accomplish dental treatment by the use of warmth, friendliness, persuasion, humor, charm, gentleness and kindness and understanding. **I understand** that treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Behavior will be guided using praise, explanation and demonstration of procedures and instruments, using variable voice tone and loudness.

8. **I understand** that should the patient become uncooperative during dental procedures with movement of the head, arms and/or legs, dental treatment cannot be safely provided. During such disruptive behavior, it may be necessary for the assistant(s) and or doctor to hold the patient's hands, stabilize the head and/or control leg movements for their safety. I also understand the routine use of "tooth pillows" (mouth props) may be necessary to be sure a child does not accidentally close their teeth while an instrument is in their mouth that could harm them. I also understand that mouth props are sometimes necessary if a child refuses to open their mouth.

9. **I understand** that it is not an uncommon response for children to cry before or during dental treatment or directly afterward when they see their parent. **I understand** the only way I can guarantee my child will not cry or be unhappy during dental treatment is if I elect to have their treatment completed in the operating room under general anesthesia. I also know conscious sedation is an option for some children.

10. For the purpose of advancing medical-dental education, I give permission for the use of clinical photographs of the patient for diagnostic, scientific, educational or research purposes.

11. All of my questions have been answered to my satisfaction and I consent to the treatment and procedures prescribed for the patient on the treatment plan.

12. **I understand** that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated except to the extent that treatment and procedures have already been performed or initiated.

13. **I confirm** that I am a legal guardian to the child referenced on the opposite page. **I also confirm** that I have read and understand this form or it was read to me, and that all blanks were filled in and all inapplicable paragraphs, if any, were stricken before I signed below.

X

Signature of Person Consenting to Treatment — Date

Signature of Doctor — Date

Witness Certification — Date

Payment and Insurance Information, Statement of Responsibility

Payment Information

As a condition of treatment by this office, all fees for private accounts are due and must be paid at the time the service is performed. In case of divorce or separated parties, documentation of financial responsibility for the patient must be provided at the time of the visit. (Please see the Statement of Responsibility, below.) Fees for proposed dental services are honored for a period of 60 days from the date of the patient's examination.

For your convenience, we offer the following methods of payment. Please check the option which you prefer.

CASH □ **CHECK** □ **VISA** □ **MasterCard** □ **DISCOVER** □

Expiration Date _____ Credit Card Account # _____Security Code_____

Cardholder Name: _____

Any other payment arrangement must be authorized by the Office Manager in advance of treatment and may be subject to a service charge of 1.5% per month (18% per year) on the unpaid balance. Account balances equal to or older than 60 days past due will be charged to the credit card you have provided.

Insurance Information

Please provide information about your dental insurance and a copy of each insurance card listed below.

PRIMARY CARRIER

Subscriber Name:_____
Subscriber SS# _____
Group Number: _____
Employer Name: _____
Insurance Name_____
Telephone # _____
How long have you had this insurance? _____

SECONDARY CARRIER

Subscriber Name:_____
Subscriber SS# _____
Group Number: _____
Employer Name: _____
Insurance Name_____
Telephone # _____
How long have you had this insurance? _____

If you would like us to submit insurance forms to your dental insurance carrier on your behalf, please sign below. We are required to keep your signature on file. Treatment plans are never submitted without your approval.

I authorize release of any information relating to this claim.

_____
Signed patient or parent (if minor)

_____
Signed insured person

Statement of Responsibility

In consideration of the professional services to my child, I agree to accept responsibility for the payment of such services. I agree to pay all costs and reasonable attorney fees incurred by my failure to remit payment for these services rendered. I grant my permission to you or your assigned representatives to telephone me at home to discuss matters related to this form. I have read the above conditions of treatment and agree in content.

Signed: _____Date:_____

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BEHAVIOR MANAGEMENT POLICY

Here at Upper East Pediatric Dentistry our goal is to treat every child in the safest, least invasive manner possible. We understand how frightening coming to the dentist can be for children. It is our goal to make their experience a pleasant one and not cause a lifetime of fearing dentist. That is why we have pediatric dentist on staff that is trained in many methods to help your child feel comfortable. For example (at an additional cost of $100), Nitrous Oxide (laughing gas) allows the child to relax so that we can complete their dental care. Every method used in our office will be specific to your child's need. Our doctor will make every attempt to use their best judgment in determining which method will best suite your child.

In our practice we occasionally find it necessary to invest beyond standard appointment time for certain children. This may be due to medical, emotional or behavioral issues. If this were to occur; there is an additional behavioral management fee of $200. This fee is related to the cost of committing the time and staff to achieve the optimum outcome for your child's dental care.

Our doctor is here to answer any questions you may have about your child's dental care and behavior management. The administrative staff will assist with all fees and insurance questions.

I have been fully informed and understand the behavior management policy.

_____ _____

Parent/Guardian Signature Date

We would like to thank you for being a part of our Upper East Pediatric Dentistry family!