PRESTON CORNERS
PEDIATRIC DENTISTRY

Welcome, and thank you for choosing our office for your child's dental care!

As a service to our patients, we will submit your insurance claim to your primary insurance company. Our office will provide the insurance company with all the information necessary to help you receive your maximum benefit. However, it is your responsibility to know your insurance coverage and the benefit limitations of your particular policy.

Helpful reminders:

- We are out of network with ALL insurance companies. There is not any direct relationship between our office and your insurance company.
- Your insurance benefits are determined by the type of plan chosen by you and/or your employer. We will file your insurance, accept the assignment of benefit, and can estimate what percentage your insurance will pay. You will be responsible for any portion of services NOT covered by your dental insurance.
- We must emphasize that as a health care provider our relationship is with you and not your dental insurance company. We do not let insurance limit the treatment we provide our patients.
- Some insurance carriers will not allow for reimbursement directly to our office. In such instances, you will be responsible for the entire cost of each visit at the time services are rendered, and the insurance company will send you the reimbursement check directly.

By the signature below, you acknowledge and understand the office insurance policy of Preston Corners Pediatric Dentistry, and allow us to communicate your dental health information with your insurance carrier.

Parent Signature: _____

Patient Name : _____

Date: _____

DEMOGRAPHIC INFORMATION

Date _____

Patient _____

Name your child would like to be called _____

Age _____ Birthdate _____ Sex _____ Home Phone _____

Email _____

Preferred number at which we can contact you if needed _____ **Emergency** _____

Home Address _____

Names and ages of other children in the family _____

School _____ Grade _____

Mother _____ SS# _____

Mother's employer _____ Phone _____

Father _____ SS# _____

Father's employer _____ Phone _____

Who has legal custody of patient _____

Who will be responsible for the account _____

Policyholder's name & date of birth _____

Dental insurance _____ yes _____ no Company _____

Whom may we thank for referring you to us? _____

What is the reason for your child's dental visit? _____

HEALTH HISTORY

Yes	No	
__	___	Is your child in good health? Name of child's physician _____
		Date of last physical exam examination _____
__	__	Has your child ever had a health problem? _____
__	__	Has your child ever been hospitalized? Please give reasons and dates _____
		_____
__	__	Is your child allergic to anything? _____
__	__	Is your child currently taking any medications? Please give medications and reason _____
		_____
__	___	Were there any problems at birth?

Please check if your child has been treated for any of the following:

☐ Heart disease	☐ Bleeding/transfusions	☐ Asthma	☐ Heart Murmur
☐ Liver disease	☐ Anemia	☐ Diabetes	☐ Autism Spectrum Disorder
☐ Kidney disease	☐ Rheumatic fever	☐ Hepatitis	☐ Sensory/Processing Disorder
☐ Speech/hearing	☐ Seizures	☐ Cleft lip/palate	
☐ Cerebral palsy	☐ AIDS	☐ Other problems	

Please elaborate _____

_____

Do you consider your child to be _____ advanced in the learning process
_____ progressing normally
_____ slow in the learning process

Was your child breast fed _____ bottle fed _____ At what age was it stopped_____

DENTAL HISTORY

Yes	No	
__	__	Has your child ever been to the dentist? Name of the dentist and date_____
		_____
__	__	Has your child experienced any unfavorable reaction from previous dental care? Please explain_____
__	__	Does your child suck a finger, thumb, or pacifier? **If yes**, Please circle which one.
__	__	Does your child have pain with chewing, yawning, or wide opening?
__	__	Does your child's jaw make a noise and is there pain associated with the sounds?

Who brushes your child's teeth and how often?_____

Please check if your child is having problems with any of the following:

☐ Cavities	☐ Toothache	☐ Teeth sensitivity
☐ Trauma	☐ Gum infections	☐ Color of teeth
☐ Orthodontics	☐ Jaw sounds	☐ Other

Comments_____

_____

Is there any additional information we should know that will help us provide a positive dental experience for your child?_____

_____

FLUORIDE HISTORY

Yes	No	
__	__	Is your home water supply fluoridated?
__	__	Does your child use a fluoride toothpaste? Were they using it before two (2) years old?_____
__	__	Do you give your child any other form of fluoride? What?_____
__	__	Does your child participate in a school fluoride rinse program?

CONSENT for DENTAL TREATMENT

I request and authorize Dr. Brooks/Dr. Chandak (and staff at their direction) to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Brooks/ Dr. Chandak to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Brooks/ Dr. Chandak provide an environment likely to help children learn to cooperate during treatment by using praise, explanation, and demonstration procedures and instruments, and using variable voice tone. Occasionally the need for gentle arm or leg restraint is required to safely complete a procedure. I will be responsible for any charges incurred on this child for dental treatment.

Signature_____ Date_____

Richard F. Brooks, D.D.S., Ritu K. Chandak, D.D.S., P.A.
Preston Corners Pediatric Dentistry

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APPOINTMENT POLICY

We are aware of school policies that make it difficult for children to be out of school for any reason. However, **MEDICAL** and **DENTAL** appointments are **EXCUSED ABSENCES** with a doctor's school note and signature stating that the child was in the office.

Although we would like to see all school-age patients after school, this is not possible. Therefore, to make certain everyone has a fair share of after school appointments, the following guidelines have been set. Please help your child and others by not asking for exceptions.

1) A **parent or legal guardian** must accompany any child under the age of eighteen to all appointments.
2) For your safety and the safety of our patients and our staff we respectfully request that **NO FOOD, DRINKS, STROLLERS, OR CELL PHONES** be in any treatment areas.
3) Children six and under will be scheduled only between the hours of 8:20 and 11:40 AM. Children, as well as adults, are more prepared and do better in the morning for these types of procedures.
4) Operative appointments (fillings, extractions, etc.) for **all** children will only be available during the morning hours.
5) Six-month oral examinations and cleaning appointments for school-age children will alternate between school and after school hours. This means you will be asked to bring your child during school hours only once or twice per year.
6) Repair or broken appliance appointments will be scheduled during school time.
7) Coming in 15 minutes late for any appointment may **require rescheduling** so we do not keep other patients waiting. Please call if you are going to be late. This will be considered a Broken Appointment.
8) If for any reason you fail to come or cancel for an after school appointment, the missed appointment will be rescheduled during school time so that we may maintain the pattern of every other appointment after school.
9) We reserve the right to charge a $40.00 missed appointment fee for broken/missed appointments. Broken appointments affect many people. If two (2) broken/missed appointments occur or two (2) cancellations without 24 hour notice, our office reserves the right to **NOT** schedule any subsequent appointments.

Your cooperation in complying with these guidelines is appreciated. We are concerned with school policies and believe these schedules will best benefit every patient. It is our desire to serve each and every one of you without causing your child to miss extensive school time. We appreciate you choosing our office for your child's dental care.

SIGNATURE _____ DATE _____

Richard F. Brooks, D.D.S., Ritu K. Chandak, D.D.S.
members, American Academy of Pediatric Dentistry
Board Certified Diplomates, American Board of Pediatric Dentistry
www.pediatricdentistcarync.com