elite PEDIATRIC DENTISTRY

Femme Ambrosio DDS MSD

Child's Name _____ Nickname_____

Sex: M ☐ F ☐ Birth Date _____ Age _____ Reason for this visit? _____

Is this your child's first dental visit? ___ Date of last visit _____ Previous Dentist_____

Your child's attitude toward previous dental care?_____

Have we seen other children in your family? _____ Names_____

How did you hear about our office?_____

MEDICAL INFORMATION

Dr.'s Name _____ Address _____ Phone_____

Is your child taking any medication? ___ What kind? _____

Reason _____

Has your child ever been hospitalized? ___ When? _____ Reason_____

Has your child had a history or difficulty with any of the following:

YES	NO		YES	NO		YES	NO	
☐	☐	Seasonal Allergies	☐	☐	Asthma/Breathing Problems	☐	☐	Arthritis
☐	☐	Autism	☐	☐	Anemia/Bleeding	☐	☐	Bones
☐	☐	Cancer/Tumors	☐	☐	Cerebral Palsy	☐	☐	Cleft Lip/Palate
☐	☐	Developmental	☐	☐	Diabetes	☐	☐	Eyes, Ears, Nose, Throat
☐	☐	Hearing	☐	☐	Heart	☐	☐	Kidney/Liver
☐	☐	Hepatitis	☐	☐	Immune Deficiency	☐	☐	Liver
☐	☐	General Anesthesia/Surgery	☐	☐	Seizures/Epilepsy/Convulsions	☐	☐	Stomach/Intestinal
☐	☐	Syndromes	☐	☐	Other _____			

Comments / Details _____

Does your child have any emotional or school problems? _____

Allergies to Medications or Food _____

DENTAL INFORMATION

Was your child bottle fed? _____ Until what age? _____ Or breast fed? _____ Until what age? _____

Does your child have any mouth habits, such as : finger/thumb sucking _____ pacifier _____ other _____

Has your child ever had any injuries to his teeth, mouth or head? _____ When? _____ Details _____

Does your child brush regularly? _____ Does an adult assist with brushing? _____

Does your child floss? _____ Does an adult assist in flossing? _____

Has either parent or child been treated orthodontically? _____ Name of Orthodontist? _____

How would you expect your child to behave in our office?_____

Describe your child: Outgoing ☐ Shy ☐ Stubborn ☐ Anxious ☐ Frightened ☐ Age Appropriate ☐

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

For Dr. Use:

_____

_____

_____

_____

elite PEDIATRIC DENTISTRY
Femme Ambrosio DDS MSD

PARENT 1

First Name _____ Last Name _____ Middle Initial ____

Address _____ City, State, Zip _____

Home Phone _____ Work Phone _____ Cell _____

Email _____ Occupation _____

PARENT 2

First Name _____ Last Name_____ Middle Initial ____

Address _____ City, State, Zip_____

Home Phone _____ Work Phone _____ Cell _____

Email _____ Occupation _____

Elite Pediatric Dentistry may leave protected Health Information (including patient's name, diagnosis, and date of service) on the following:

☐ Home Phone ☐ Work Phone ☐ Cell Phone ☐ Email

FINANCIAL POLICY and AUTOHRIZATION

In my absence, I hereby give authorization for the person(s) listed below to bring my child(ren) to Elite Pediatric Dentistry and to consent for any and all recommended dental/medical services.

Authorized person(s)	Relationship to child(ren)	Contact Number
_____	_____	( ) - .
_____	_____	( ) - .
_____	_____	( ) - .

Your child's estimated share of cost is due and payable on the day the treatment is performed, unless prior approved financial arrangements have been made. Understand that dental insurance may cover only part of your child's dental treatment, based on your specific dental benefit plan. We will do our best to provide you with an estimate based on your plan. Please understand that the contract for dental insurance is between you and your insurance company. Any disputes of coverage need to be handled through the insurance company directly by you. By signing, I accept as my personal responsibility all charges to my child's account regardless to any insurance coverage.

To avoid missed appointment charges we request that cancellations are made 48 hours prior to the appointment. In doing so this appointment may then be made available to another family. A charge of $50.00 will automatically be placed for two consecutive broken appointments. A broken appointment is considered a "no show" or cancelling an appointment the same day.

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to determine appropriate and healthful dental treatment. If there is any change in my child's medical status I will inform the dentist.

I authorize the dental insurance company provided to this office, to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

SIGNATURE _____ **RELATIONSHIP TO CHILD** _____ **DATE** _____