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Pediatric Dentist and Orthodontist
Suzanne Duvalsaint, DDS
Orthodontist
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Pediatric Dentist

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Orthodontics

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Pediatric Dentistry

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(212) 362-3355 Fax: (212) 362-3356

PEDIATRIC PATIENT INFORMATION:

Name: _____ (Nickname: _____)

Date Of Birth: ___ / ___ / ___ Sex: M F Child's School: _____

Address: _____ Apt. #: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: _____ Cell Phone#: _____ (circle preferred #)

Siblings who are patients of our practice: _____

Whom may we thank for referring you? _____

PARENT'S INFORMATION:

PARENT'S INFORMATION:

Name: _____ Name: _____

Date of Birth: _____ Date of Birth: _____

Occupation: _____ Occupation: _____

Work Phone # _____ Work Phone# _____

Cell Phone# _____ Cell Phone# _____

Email: _____ Email: _____

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

Parent's Name: _____

Address: _____ Apt. # _____

City: _____ State: _____ Zip Code: _____

Emergency Contact (name and phone number): _____

MEDICAL HISTORY:

Date of last check up: ___ / ___ / ___
Name of Pediatrician: _____ Phone #: _____
Address: _____ Suite: # _____
City: _____ State: _____ Zip Code: _____

Has your child been diagnosed with any of the following? Please circle all that apply:

- | | |
|--|-------------------------------------|
| ADD / ADHD | Ear Infections |
| Allergies | Fainting |
| Anemia | Hearing loss |
| Asthma | Heart murmur |
| Autism | Intestinal Problems |
| Bleeding disorder (anemia, prolonged bleeding) | Learning Disability |
| Cardiac conditions | Liver disease/Hepatitis |
| Cancer, malignancies, tumors | Muscular/coordination disorder (CP) |
| Diabetes | Renal/ Kidney Disease |
| Respiratory Problems | Speech delay |
| Rheumatic Heart Disease | Thyroid Problems |
| Rheumatoid Arthritis | Tuberculosis |
| Seizure disorder | Visual Disorder |
| Sinus problems | |

DAILY MEDICATIONS (PLEASE LIST ALL): _____

Major/ Minor Surgery Y N If yes, please explain: _____
Hospitalizations Y N If yes, please explain: _____

Was the term of your pregnancy and birth of your child normal? Y N
If not, please explain: _____

Has your child had any disease or medical issues not mentioned above? Y N
If yes, please explain: _____

Has your child had an unusual experience with any anesthetic? Y N
If yes, please explain: _____

Does your child undergo regular MRI's for any reason? Y N

Allergies to medication (PLEASE LIST ALL): _____

Latex allergy/food allergy: _____

DENTAL HISTORY:

Is this your child's first visit to the dentist? Y N

Purpose of today's visit:

How many times a day does your child brush his/her teeth? _____ With adult assistance? Y N

Does your child floss his/her teeth?_____

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

Does your child have any of the following habits: Finger/thumb sucking Pacifier Use

Does your child drink tap water, bottled water, or both (Please circle)

Does your child take vitamins supplemented with fluoride? Y N

Is your child currently having any dental discomfort? Y N

If yes please explain: _____

Is your child currently being treated by an orthodontist? Y N

Name of orthodontist: _____

How does your child behave with the pediatrician? _____

Consent For treatment

I hereby give my consent to Margot Jaffe, D.D.S., Suzanne Duvalsaint, D.D.S, Caryn Siegel, D.M.D., and their associates to treat my child. I authorize the treating dentist to provide any information to other doctors for the purpose of consultation. I understand that prior to providing any treatment I will be advised about it by the dentist or hygienist, 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.

Parent's Signature: _____ Date: _____

Print Parent's Name: _____

For future appointments, if you are planning to send your child with someone other than a legal guardian, please provide the following information:

Name of authorized person: _____

Please do not write below this line

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

OFFICE POLICIES:

Missed appointments:

If you are unable to keep your child's appointment, we would appreciate at least 24 hours notice if at all possible. This will help us utilize that time for another patient who requires an appointment. We would be glad to reschedule your appointment at a more convenient time if necessary. We reserve the right to charge for missed appointments.

(over)

Emergencies:

Unfortunately dental emergencies do arise. We will make every effort to assess your child's emergency on the phone and make him/her an appropriate appointment. Based on our experience and the type of emergency we can determine how urgently we need to see your child. We prefer to see emergencies in the earlier part of the day when the office tends to be quieter. We also ask for your patience when we might be delayed in seeing your child due to an urgent situation with another patient.

Financial Policy:

We are delighted to welcome your child to our practice and we are pleased that you have chosen us to serve your child's dental needs. The following is a statement of our financial policy, which we require you to read and sign and the bottom of this page:

Payment is expected at the time services are rendered; the parent who accompanies the patient to the appointment will be responsible for payments. If you are unable to be with your child at the time of his/her appointment, payment arrangements should be made prior to the dental visit.

If you have concerns or questions regarding this policy, please feel free to discuss this with our head administrator.

Our practice does not participate with insurance, but we can give you a Doctor's statement (Insurance form), and the member will be responsible for submitting the information to the Insurance Company for reimbursement.

Payment methods:

We accept Visa, Master Card, American Express, Discover, Personal checks*, and Cash.

*All returned checks are subject to a twenty-five dollars service charge

Credit Card authorization:

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

_____ I hereby authorize Dr.'s MARGOT JAFFE, D.D.S., SUZANNE DUVALSAINT, D.D.S, & CARYN SIEGEL, D.M.D. to keep my credit card on file, in which it could be used to charge any visits my child has, as well as to clear any balances on my account.

We will mail the statement with a copy of your credit card receipt.

Cardholder's Name: _____

Card type: VISA – MC - AMEX- DISCOVER

Card Number: _____ Expiration Date: _____

Billing Zip Code: _____

Cardholder's Signature: _____