NY Kids Dentistry and Orthodontics

110 E. 87th Street, #1A, New York, NY 10128
212-369-2213

130 W. 86th Street, #1A, New York, NY 10024
212-362-3355

ADOLESCENT ORTHODONTIC PATIENT INFORMATION:

Name: _____ (Nickname: _____)

Date Of Birth: ___/___/_____ Sex at birth: M F Gender: _____ Pronouns: _____

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):_____

Suzanne Cirino Duvalsaint, DDS, MS Orthodontics
Caryn Siegel, DMD Diplomate American Board of Pediatric Dentistry
Keith Goldman, DMD MS Orthodontics
Margot Jaffe, DDS
Yena Jun, DDS
Matthew Stout, DMD Orthodontics
Jaqueline Dikansky, DDS
Sydney Shapiro, DDS American Board of Pediatric Dentistry

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

DAILY MEDICATIONS (please list all):_____

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

ALLERGIES TO MEDICATIONS (please list all):_____
LATEX ALLERGY/ FOOD ALLERGY (please list all):_____

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

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DENTAL HISTORY:

Name of child's dentist:_____ Phone #: _____ Date of last examination: _____

Has your child had previous orthodontic treatment?_____Date:_____
Any injuries to teeth or face? _____ If yes, please explain: _____
Bleeding/Sore gums?_____
Do you know of any sore spots or growths in/around mouth?_____
What do you feel is wrong with your child's teeth?_____
_____

Oral Habits

How often does your child brush his/her teeth? _____ Floss? _____
Does your child grind his/her teeth?_____
Does your child experience any TMJ discomfort?
_____

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:_____

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

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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.

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.

Acknowledgement of receipt of Notice of Privacy Practices:

I_____, hereby acknowledge that I have been given the right to review JAFFE, D.D.S., DUVALSAINT, D.D.S, & SIEGEL, D.M.D. Notice of Privacy Practices (HIPAA).

_____
Parent's/Legal Guardian Signature

Print Name: _____

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Financial Policy:

We value you and your family as patients and appreciate that you have entrusted us with your dental needs. The following is a statement of our financial policy which we require you to read and sign at the bottom of this page:

As you know there is a charge for the pediatric dental and orthodontic services that we provide. Payment is expected at the time services are rendered. For Pediatric dental visits, as a courtesy we are happy to complete all necessary documentation and submit it to your insurance provider, for reimbursement directly back to you. For all Orthodontic services, a form will be provided and you will be responsible for submitting to your insurance company for reimbursement. (Please see the front desk for more information).

Please bring your insurance information and a valid ID to your or your child's visit.

Since you are ultimately responsible for payment for treatment it is our policy to obtain your credit card number and authorization to process claims for payments. By presenting your credit card to the receptionist at the front desk, you authorize without prior notification, payment by credit card for services for the amounts you are obligated to pay (for both pediatric dental and orthodontic services). If you would like to use an alternative method of payment please inform us prior to the appointment.

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

☐ I choose **NOT TO** leave a credit card on file and I understand that payment in full is due at the time of service. **Late payments will incur a 2% administrative fee.**

Any patients entering or enrolled in a payment plan for orthodontic treatment are required to leave a credit card on file.

There may be a cancelation/no show fee if the patient is not able to make their appointment without giving a 24-hour notice.

Patient's Name: _____ Parent/Guardian's Name _____

Cardholder's Signature:_____Date: _____

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