Fern E. Cytryn, D.D.S., FAAPD
Diplomate
American Board of Pediatric Dentistry

Pediatric and Adolescent Dentistry
of Rockland County, P.C.

Update Form

Please complete before each
Check-up Appointment

Today's Date_______________

Child's Name________________________ Date of Birth_____________
Address____ Home Phone________________
Mother's Name___________________ E-mail___________________
Work Phone____________________ Cell Phone_______________
Father's Name___________________ E-mail___________________
Work Phone____________________ Cell Phone_______________
Dental Insurance Company_______________________________________
Is this New? Yes No
Policy Holder____
Date of Birth______________________ SSN_____________________
Employer____
Group Number______________________ ID Number______________________
Phone Number____

Is your child in good health? Yes No
Pediatrician's Name___________________________ Phone Number________________________
Date of last appointment_______________ What was this appointment for?____________

Since your last appointment:
Has your child had any medical concerns? Yes No
____
Is your child allergic to anything? Yes No
Medications or foods?_____________________________
Is your child taking any medication? Yes No
____
Has your child been hospitalized or had surgery? Yes No
____
Is your Pediatrician prescribing your child's fluoride supplement? Yes No
What is the dose?____
Is it liquid or chewable tablets?____________________________
When does your child take their flouride?_____________________
Does your child participate in any sports or physical activities? Yes No
What type?____
Is your child wearing a mouth guard? Yes No
What type of mouthguard?______________________________________

Parent's Signature_____________________________________
Relationship____

16 Squadron Blvd. Suite 101
New City, NY 10956
(845) 634.3200
drfernsmile.com

Pediatric And Adolescent Dentistry Of Rockland County, P.C.

Acknowledgement of Receipt of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices.

Parent Print Name: ______________________________

Parent's Signature: ______________________________

Date: ______________________________

Children('s) Name(s): ______________________________

Name and Relationship of Individuals Allowed to Receive Information, including School:

1. ______________________ 3. ______________________

2. ______________________ 4. ______________________

How would you like us to communicate with you?

Our dental office sends appointment reminders, information about treatment, payment and insurance, and other communications. Please tell us how you would like us to communicate with you.

Check or complete all that apply (please print clearly):

Contact me by U.S, Mail at the following address: ______________________________

Contact me by E-mail at the following E-mail address ______________________________

For Phone Communications

Phone Number: Home______________________ Cellular/Mobile ______________________

____**By checking this, I consent to the following:** This dental practice or its service provider may contact me by telephone to provide health care information such as appointment reminders and information for treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing.

Please notify us right away when you get a new telephone number. ______________________

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy and Communication Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign Date/Initials: ______________________
- ☐ Communications barriers prohibited obtaining the acknowledgement Date/Initials: ______________________
- ☐ An emergency situation prevented us from obtaining acknowledgement Date/Initials: ______________________
- ☐ Consent revoked Date/Initials: ______________________
- ☐ Confirmed Accurate: Date/Initials ____________ Date/Initials ____________ Date/Initials ____________

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CONSENT FOR DENTAL TREATMENT

Patient's Name: ________________________
Date of Birth: ________________________

I authorize Dr. Cytryn to treat my child for general dental care including dental caries and infections. Care will include dental hygiene, x-rays, maintenance of space between teeth and when appropriate, extractions.

Dr. Cytryn has discussed with me the following information:

A. The benefits of general dental care are clean teeth, good dental health and the eradication of decay and infection when they are found.

B. The risks and/or complications of routine dental care are sore gums, possible gingival soreness due to the use of rubber dams, and soreness at the site where a local anesthetics is injected.

C. If routine dental care is not received the following conditions may occur: progression of decay, pain and swelling, infections of the teeth or gums and surrounding boney areas. It has been explained to me that infections and the premature loss of "baby" teeth may affect the development of adult teeth, and/or cause tooth movement with can negatively effect the eruption of adult teeth.

It has been explained to me that other risks not usually encountered or expected may occur since dentistry is not an exact science and some patients react differently than others. I acknowledge that no guarantees have been made to me about the results of the proposed treatment and that maintaining good dental health requires active patient participation in oral hygiene.

I authorize the administration of local anesthetics, hypnotics and/or analgesics to aid and assist in completing the treatment by Dr. Cytryn.

I have had the opportunity to discuss my child's dental condition and the proposed treatment plans with Dr. Cytryn. All of my questions have been answered to my satisfaction. I impose no specific limitations or prohibitions regarding treatment.

I have the legal authority to sign this consent on behalf of ________________ and my relationship to the patient is that of ______________________.

____
Parent - Print Name

____________________________ ________________________
Parent Signature Date

____________________________ ________________________
Dentist Signature Date

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