dr.fern
Pediatric dentistry with a smile!

New Patient Form

Today's Date:

NOTE: The parent or guardian who accompanies the child is responsible for payment at the time of service.

1 TELL US ABOUT YOUR CHILD

Child's Name: _____
Last First Middle

Nickname: _____ ☐ Male ☐ Female

Siblings that we treat: _____

Child's Birthdate: ____/____/____ Child's Age: _____

School: _____

Child's Home #: (____)_____

SSN: _____

Child's Home Address: _____

_____
City State Zip

2 MOTHER'S INFORMATION

Name: _____

Mother Stepmother Guardian Birthdate ____/____/____

Address: _____

_____
City State Zip

Employer: _____

Present Position: _____ How Long Held?_____

Work #: (____)_____

Home #: (____)_____

Cell #: (____)_____

SSN: _____ DL#: _____

Email Address: _____

3 FATHER'S INFORMATION

Name: _____

Father Stepfather Guardian Birthdate ____/____/____

Address: _____

_____
City State Zip

Employer: _____

Present Position: _____ How Long Held?_____

Work #: (____)_____

Home #: (____)_____

Cell #: (____)_____

SSN: _____ DL#: _____

Email Address: _____

4 WHO MAY WE THANK FOR REFERRING YOU?

_____

5 WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____

Relationship: _____

Do you have legal custody of this child? ☐ Yes ☐ No

6 PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

Relationship: _____

Billing Address: _____

_____
City State Zip

Work #: (____)_____

Home #: (____)_____

Cell #: (____)_____

Email Address: _____

7 PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (____) _____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____

SSN: _____

Policy Owner's Employer: _____

8 SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Co. Phone #: (____)_____

Group # (Plan, Local, or Policy #): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/____

SSN: _____

Policy Owner's Employer: _____

9 DENTAL HISTORY

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

If not, how long since the last visit to the dentist? _____

Previous dentist's name: _____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain: _____

_____

_____

Why did you bring your child to the dentist today? _____

_____

_____

Does the child have any of the following habits?

Y N Lip Sucking / Biting
Y N Nail Biting
Y N Nursing / Bottle Habits
Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? YES NO

If yes, please explain: _____

_____

Is the child's water fluoridated? YES NO

Is the child taking fluoride supplements? YES NO

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD)? YES NO

Does the child brush his/her teeth daily? YES NO

Floss his / her teeth daily? YES NO

10 HEALTH HISTORY

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding
Y N Allergies to any Drugs
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Congenital Birth Defects
Y N Convulsions/Epilepsy
Y N Pregnancy
Y N Tuberculosis
Y N ADD/ADHD
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Disease/Murmur
Y N Hepatitis
Y N HIV + / AIDS
Y N Kidney/Liver Conditions
Y N Rheumatic/Scarlet Fever
Y N Allergies to Latex Product
Y N Diabetes
Y N Hemophilia/Blood Disorders
Y N Reflux/GI Problems

Please discuss any serious medication conditions the child has had:

_____

_____

Please list all the drugs the child is currently taking: _____

_____

Please list all drugs the child is allergic to: _____

_____

Child's Physician: _____

Phone #: (____) _____

Is the child currently under the care of a physician? YES NO

Please describe the child's current physical health:

GOOD FAIR POOR

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA the CDC, and the ADA.

11

I consent to the diagnostic and treatment procedures necessary for dental care by Dr. Cytryn.

I consent to the use and disclosure of my child's records that are related to treatment or payment.

I under stand that my dental insurance carrier/payor may pay less than the actual bill for services, and by signing this statement I agree that I am financially responsible for payment in full for all accounts.

I certify that all information which I have provided is accurate.

Signature of Parent or Guardian _____ Date _____ Relationship to Patient _____

dr.fern

Fern E. Cytryn, D.D.S., FAAPD
Diplomate
American Board of Pediatric Dentistry
Pediatric and Adolescent Dentistry
of Rockland County, P.C.

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

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

dr.fern

Fern E. Cytryn, D.D.S., FAAPD
Diplomate
American Board of Pediatric Dentistry
Pediatric and Adolescent Dentistry
of Rockland County, P.C.

We are dedicated to providing your child with the best possible care. Your knowledge and understanding of these policies is important for our professional relationship.

As a Pediatric Dentist my relationship is with you and your child. Your dental insurance policy is a contract between you, your employer, and your dental insurance company. This office is not responsible for how your insurance company handles its claims, or what benefits the plan pays on a claim. If we are an out of network provider, we will assist you in providing information the insurance company needs to process the claim. We will provide a claim form to assist you if secondary insurance is involved.

All parents must complete our patient registration forms prior to seeing the Doctor. The parent who brings the child is responsible for the account balance; regardless of the family situation or who carries the insurance.

1. Payment: Payment in full for treatment services is due at the time the services are rendered. We currently accept Cash, Checks, Master Card, Visa, and Discover for payment. We do not hold checks or accept post-dated checks.
2. Insurance: The only insurance plans this office participates with is the Delta Dental Premier Plan, and those classified under the Dentemax network. In the event that there is an outstanding balance from Delta Dental or your specific Dentemax Plan, that account balance is your responsibility and payment is expected at the time of service.
   Whatever your insurance plan, we will still need a copy of your insurance card as it provides the information needed for your claim form's completeness. If you do not have a card, contact your plan.
3. Account Payment: You are responsible for the timely payment of your account. Payment is expected within 30 days of the date on the account statement. There is a 1 ½% finance charge on any unpaid balance for each month your balance is outstanding. In addition there is an added administrative fee of $25.00 to your account for each month your balance remains unpaid. We understand that temporary financial problems may occur which affects timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in the management of your account.
4. Non-Payment: If your account is 30 days past due you will receive a letter stating that you have 14 days to pay your account in full. Partial payments will not be accepted. Please be aware that if a balance remains unpaid you will be subject to additional fees that are incurred to collect your balance; including but not limited to administrative, legal, collection agency, etc...
5. Returned Checks: Returned checks are subject to an additional fee. A $50.00 charge for the returned check will be applied to your account balance.
6. Appointments: All patients must be accompanied by their parent for all treatment appointments, and be present during treatment. Once an appointment is made, this time has been specially and specifically reserved for your child. A $75.00 charge will be assessed unless the office is notified 24 hours in advance.
   We understand that unfortunately emergencies can occur. Please let us know as soon as it is feasible so that we can reschedule your child's appointment.
7. Treatment Plan: We will gladly discuss any proposed treatment with you, provide a treatment plan, and answer your questions.
8. Fees: This office's fees are representative of this area.

Thank you for taking the time to review our policies.

I have read and understand these policies and agree to abide by its guidelines.

Patient Name/Names _____

Parent/Guardian Signature _____

Date _____

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Acknowledgement of Receipt of Notice of Privacy Practices

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

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:

_____

_____

For Office Use Only

_____

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

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

Effective September, 2013; Retroactive to December, 2007

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Fern E. Cytryn, D.D.S., FAAPD
Diplomate
American Board of Pediatric Dentistry
Pediatric and Adolescent Dentistry
of Rockland County, P.C.

Record Transfer

To: _____

_____

_____

Re: **Patient:** _____ DOB: _____ M/F

Patient: _____ DOB: _____ M/F

Parent: _____
Print Name

_____ _____
Signature Date

Please forward my child/children's dental records to:
Pediatric And Adolescent Dentistry Of Rockland County, P.C.
16 Squadron Blvd Suite 101
New City, NY 10956

Thank you.

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