We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventative care. We strive to teach good oral care that will enable your child to have a beautiful smile that will last a life time.

MOTHER OR GUARDIAN:

Last Name:_____

First Name:_____

Date of Birth:_____

Social Security #:_____

Address:_____

City:_____

State:_____

Zip Code:_____

Cell Phone:_____

Home Phone:_____

Work Phone:_____

Email:_____

FATHER OR GUARDIAN:

Last Name:_____

First Name:_____

Date of Birth:_____

Social Security #:_____

Address:_____

City:_____

State:_____

Zip Code:_____

Cell Phone:_____

Home Phone:_____

Work Phone:_____

Email:_____

•TELL US ABOUT YOUR CHILD

Male □ Female □

Child's Last Name:_____

Child's First Name:_____

Child's Date of Birth:_____
Age:_____ Social Security #:_____

Name of person accompany the child today:_____

Do you have custody of the child: **YES** or **NO**? If not who does_____

Who is financially responsible for this account?_____

Primary Care provider (**DOCTOR**):_____
Phone #:_____

•IN CASE OF AN EMERGENCY PLEASE CONTACT

Name:_____
Phone #:_____

Relationship to patient:_____

•MEDICAID PATIENTS ONLY! PLEASE CHECK THE BOX:

□Presbyterian □United Healthcare □Molina
□ACS □Blue Cross Blue Shield

WHO MAY WE THANK FOR REFFERING YOU?_____

If referred by a doctor please list name:_____ Phone #_____

Office Name:_____

What is the reason for bringing your child into the office today?_____
_____

Child's last visit to the dentist:_____

Name of your previous dentist:_____

Please check box if applies:

Has your child ever had a serious/difficult problem associated with previous dental work? □YES □NO

Has the child ever had any pain or tenderness in their jaw? □YES □NO

Does your child brush their teeth daily? □YES □NO □SOMETIMES

Does your child floss their teeth daily? □YES □NO □SOMETIMES

Please describe your child's current health □GOOD □FAIR □POOR

Please list all drugs that your child is currently taking:_____
_____

(Please check all that apply)

□Abnormal Bleeding
□Asthma
□Cancer
□Allergies to any medications
□Any hospital stays
□Convulsions
□Any operations
□Hearing Impaired
□Congenital Heart Defect
□Heart Murmur
□Handicaps/Disabilities
□Hemophilia
□Hepatitis
□HIV/AIDS
□Kidney/Liver Problems
□Tuberculosis (TB)
□Rheumatic/Scarlet Fever

Does your child have any of the following habits? □Lip Sucking □Thumb Sucking □Bottle Habits □Nail Biting

Please discuss any serious medical problems that your child has had:_____
_____

Please list any drugs that your child is allergic to:_____
_____

I understand that the information that I have given is correct to the best of my knowledge and that it will be held in the strictest confidence. It is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform all necessary x-rays to enable complete diagnosis and treatment.

_____ _____
SIGNATURE OF PARENT OR GUARDIAN DATE

DENTAL TREATMENT CONSENT FORM

Dentist Name:_____ Patient's Name:_____

□**X-rays**: A dental assistant reviewed the importance of having radiographs done if your child is uncooperative and unwilling to take x-rays there may be a possibility of interproximal decay. If I refuse to have my child take radiographs then I am putting my child at risk for possible decay. _____

□**Drugs and Medications**: I understand that antibiotics, analgesic, and other medications can cause an allergic reaction causing redness, swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction). _____

□**Treatment, Changes in Treatment, and Estimates**: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during the examination. All payments must be made on the date the treatment is rendered. _____

□**Removal of Teeth**: Alternatives to removal have been explained to me (root canal therapy and crowns) I authorize the dentist to remove the following teeth. TOOTH #____ I understand that removing teeth does not always remove the infection if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are in pain, swelling, and spread of infection, dry socket, loss of feeling in my teeth, lips, tongue, and surrounding tissue (Parethesia) that can last for indefinite period of time (days or months) or fractured jaw. I understand I may need further treatment by a specialist or even hospitalization if complications arise during the following treatment, the cost of which is my responsibility. _____

□**Crowns, Bridges, and Caps**: I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I understand that there is a possibility that the crowns may be become loose or they may come out. I understand if I lose or misplace a crown that insurance will not cover another therefore it will be an out of pocket charge. I understand that if my child's crown falls off, I should schedule an appointment immediately with Dr. Cito to recement it. If I do not take my child in to recement the crown there can be a possibility of my child's teeth shifting. _____

□**Pulpotomy Treatment**: I realize that there is no guarantee that Pulpotomy treatment will save my child's tooth, and that complications can occur from the treatment. _____

□**Fillings**: I understand that care must be exercised in chewing on fillings especially during the first 24 hours to avoid breakage. I understand that a more expensive filling that initially diagnosed may be required due to additional decay. I understand that significant sensitivity is a common after effect for a new placed filling. Dr. Cito's office will automatically place amalgam (silver) fillings unless you request otherwise. _____

□**Hospital Sedation**: I understand that my child had extensive amount of work and is highly uncooperative at Dr. Cito's office therefore the need to be sedated under general anesthesia. I understand that the risks of going under general anesthesia are, death, vomiting, and nausea._____

I understand that dentistry is not an exact science and that, therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Parent/Guardian:_____ Date:_____

Appointment Policy

We thank you for choosing for Dr. Stephen Cito and staff for your child's dental needs. We ask from you that if you need to reschedule any future appointments that you give us a 24hr notice. Unfortunately if there are more than 3 no shows or rescheduled appointments we will no longer be able to see your child/children for future appointments. We allow no more than 3 no shows or reschedules because of our high volume or patients that we see daily. We advise you to pick a time that is convenient for you so we can make sure to block a specific time just for your child to get the very best treatment at Dr. Cito's.

Thank you,

Stephen M. Cito (D.D.S)

By signing you are aware of our appointment policy here at Dr. Cito's Pediatric Dental Office!

Parent Signature:_____

Date:_____