



South Shore Children's Dentistry  
Kristine A. Grazioso, D.M.D.  
Mina M. Schafft, D.M.D.

Reviewed by:
Dr.
Date

## PATIENT INFORMATION

Child's First and Last Name \_\_\_\_\_ Nickname \_\_\_\_\_  
D.O.B. \_\_\_\_\_ Sex: Male \_\_\_\_\_ Female \_\_\_\_\_ Telephone#: (\_\_\_\_) \_\_\_\_\_

Mailing Address: Street \_\_\_\_\_  
City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Mother's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ S.S.# \_\_\_\_\_  
Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business #: (\_\_\_\_) \_\_\_\_\_ Cell#: (\_\_\_\_) \_\_\_\_\_  
E-mail address \_\_\_\_\_

Father's Name \_\_\_\_\_ D.O.B. \_\_\_\_\_ S.S.# \_\_\_\_\_  
Employed by \_\_\_\_\_ Occupation \_\_\_\_\_  
Business #: (\_\_\_\_) \_\_\_\_\_ Cell#: (\_\_\_\_) \_\_\_\_\_  
E-mail address \_\_\_\_\_

Marital Status: \_\_\_\_\_ Married \_\_\_\_\_ Single \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Other \_\_\_\_\_

Child Lives With: \_\_\_\_\_ Both Parents \_\_\_\_\_ Mother \_\_\_\_\_ Father \_\_\_\_\_ Other \_\_\_\_\_

\*All office correspondence will go to the address where the child resides.

Name and Age of Siblings: \_\_\_\_\_

Who may we thank for referring you? \_\_\_\_\_

Child's Pediatrician \_\_\_\_\_ Date of last visit \_\_\_\_\_  
Address \_\_\_\_\_  
Phone# (\_\_\_\_) \_\_\_\_\_

Child's Previous Dentist \_\_\_\_\_ Date of last visit \_\_\_\_\_  
Address \_\_\_\_\_  
Phone# (\_\_\_\_) \_\_\_\_\_

## DENTAL INFORMATION

Reason(s) for seeking dental care:

_____ First examination	_____ Second Opinion	_____ Appearance of teeth
_____ Routine check-up	_____ Accident	_____ Consultation
_____ Toothache or swelling	_____ Other _____	

Do you have any concerns or issues regarding your child's dental health that you would like addressed?  
\_\_\_\_\_

Has your child had any negative dental experiences? \_\_\_\_\_ If yes, please explain \_\_\_\_\_

How do you expect your child to react to the visit today?  
\_\_\_\_\_ Excellent \_\_\_\_\_ Good \_\_\_\_\_ Fair \_\_\_\_\_ Poor \_\_\_\_\_ Don't know

Please check any of the following that may describe your child:  Outgoing  Shy  
 Cooperative  Anxious  Stubborn  Trusting  Friendly  Moody

Does your child receive fluoride in any of the following forms?  
 In Vitamins  In Water Supply  Drops/Tablets  Rinse/Gel

Does your child brush daily?  Yes  No  
Does an adult assist with the brushing?  Yes  No  
Does your child use dental floss?  Yes  No

Does your child have any of the following habits?  
 pacifier  thumb sucking  finger sucking  bottle with milk or juice in bed  
 teeth grinding  mouth breathing

Have your child's teeth ever been injured?  Yes  No  
If yes, at what age? \_\_\_\_\_ Which teeth? \_\_\_\_\_  
Cause? \_\_\_\_\_ Treatment received? \_\_\_\_\_

## MEDICAL INFORMATION

Is your child being treated for any condition presently?  Yes  No  
If so, explain \_\_\_\_\_

Is your child taking any medications?  Yes  No

Drug	Reason

Has your child ever had an allergic or unusual reaction to a medication or drug?  Yes  No  
If yes, explain \_\_\_\_\_

Does your child have any allergies to the following?  
 Latex  Foods  Food Dyes  Other

Has your child ever been hospitalized?  Yes  No  
If so, explain \_\_\_\_\_

Has your child had any surgery?  Yes  No  
If so, explain \_\_\_\_\_

Was general anesthesia used?  Yes  No  
Were there any complications? \_\_\_\_\_

Are your child's immunizations current?  Yes  No



Insurance Information

For those patient covered by dental insurance

Subscriber's Name: \_\_\_\_\_ Subscriber ID#: \_\_\_\_\_  
Subscriber's DOB: \_\_\_\_\_ Subscriber's Employer: \_\_\_\_\_  
Insurance Co. Name: \_\_\_\_\_ Group #: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_  
Insurance Phone #: \_\_\_\_\_

Financial Information, Terms and Conditions

This statement is to inform you of our financial policy. We are committed to providing your child with the highest quality dental care using only the best material available in dentistry today in a child-friendly environment. Our financial policy is intended to facilitate excellent service to you while minimizing our administrative costs.

As a condition of treatment by this office, fees must be paid at the time the service is performed. All charges you incur are your responsibility regardless of your insurance coverage. **We must emphasize that as your dental care provider, our relationship is with you, our patient, not with your insurance company.** As a courtesy to you, we will help you process all your insurance claims. This office will accept assignment of benefits providing you pay all co-payments and patient deductibles at the time of the visit. Any insurance payment not received in 45 days from the date of service will be charged to your account. We accept no responsibility in collecting overdue insurance claims or negotiating settlement on disputed claims.

Payment of your portion of the charges, whether a part of or the total amount, is due on the date of service, unless other specific arrangements have been made prior to treatment. Our office accepts cash, personal checks, MasterCard, and Visa. Returned checks are subject to a \$35.00 fee. Balances over 60 days old become the sole responsibility of the patient, even if insurance benefits are expected. Additionally, our office will charge you for broken appointments and appointments cancelled without 24-hour advance notice a fee of \$50.00.

**By signing below, I understand and agree to the terms described herein and agree to accept responsibility for the payment of services.** I agree to pay all costs incurred by my failure to remit for services rendered, including fees charged by a collection agency. I grant my permission to you, or your assigns, to telephone me at home or at my work to discuss matters related to this form. Furthermore, I authorize the dental benefits otherwise payable to me to be paid directly to Dr. Kristine A. Grazioso. **I have read the above conditions of treatment and agree in content:**

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date

Consent for Treatment

I hereby give my consent to Kristine A. Grazioso, DMD and Staff to treat my child which may include the following dental procedures: complete dental examination (check-up), prophylaxis (cleaning), fluoride treatment, radiographs (x-rays), sealants, study models, and other diagnostic/preventative aids deemed necessary by Dr. Grazioso or her staff to make a thorough diagnosis of my child's dental needs.

I authorize Dr. Kristine Grazioso and staff to provide any information to other Doctors (Physicians, Dentists, etc.) for the purpose of consultation. I understand that prior to providing any treatment I will be advised about such treatment, that I may ask questions concerning the treatment, and that I may revoke this consent BEFORE treatment is provided.

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

Name of authorized person(s) to accompany my child for future treatment visits:

1. Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_
2. Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_
3. Name: \_\_\_\_\_ Relationship to Child: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date