Fort Lee
Pediatric Dental Associates

MICHAEL KASSELIAN, D.D.S.
Patient Information and Health History

Child's Name: ____________ ____ ____________ Male / Female Birth Date: __________
First MI Last

Address: ______________________ City/state: ________ Zip: ______ Phone #: _____-_____-_____

Father's Name: ______________ Social Security #: ____________ Date of Birth: __________

Occupation: ______________ Employer ________________ Cell Phone# ____-____-_____

Email: ________________________________ Work Phone#: _____-____-_____

Mother's Name: ______________ Social Security #: ____________ Date of Birth: __________

Occupation: ______________ Employer ________________ Cell Phone#: ____-_____-_____

Email: ________________________________ Work Phone#: ____-____-_____

Who may we thank for referring you? ________________________________

Family Dentist: ______________ Child's Physician: ____________ Phone#: ____-_____-_____

Name and Grade of School the Child Attends: ________________________________

Is your child taking any multivitamins? ________________________________

Is your child taking vitamins w/ fluoride? ________________________________

Please list any medications being taken now or recently by your child:

____

Has your child had any allergic reactions to :

- Food or Food dyes YES / NO
- Medicines YES / NO
- Anesthetics (local or general) YES / NO
- Others
  Please Describe: ________________________________

Has your child ever been hospitalized? YES / NO

If yes, give details: ________________________________

Does your child have a heart murmur or heart defect? YES / NO

If yes, give details and name of Cardiologist if available: ________________________________

Please check all that apply to the patient, present and past conditions:

__Measles	__Diabetes	__Bleeding Problems	__AIDS or AIDS related complex
__Chicken Pox	__German/"3day" measles	__Asthma or Wheezing	__Skin Problems
__Mumps	__Hearing Difficulties	__Rheumatic Fever	__Bone and Joint Problems
__Scarlet Fever	__Speech Difficulties	__Kidney Disease	__Growth Abnormalities
__Pneumonia	__Emotional Difficulties	__Tuberculosis	__Whooping Cough
__Birth Defects	__Fainting or Dizziness	__Epilepsy or Seizures	__Broken Bones
__Poor Vision	__Sickle Cell Anemia	__Serious Accidents	__Liver disease or Hepatitis
__Anemia	__Removal of Tonsils or Adenoids	__Cancer	__

Does your child have any of the following ? ____Autism ______ADD _______ADHD________Other

______________________________ ______________________________
Signature Date Print Name Date

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Dental History and Information

Is this your child's first dental visit? YES / NO

If not, when was his/her last visit and for what reason? ______________________________

- Were X-rays taken? YES / NO
- Sedation used? YES / NO
- Nitrous Oxide used? YES / NO
- Local Anesthetic used? YES / NO
- Was his/her behavior ······ Positive / Negative

What is the main reason for bringing your child today? ______________________________

Does your child have any of the following habits? Check all that apply.
__Thumb Sucking
__Using the bottle
__Mouth Breathing
__Tongue Thrusting
__Speech Problems
__Grinding of the teeth
__Pacifier
__ Other

Has your child ever had any injury to the face or teeth? YES / NO
If so, please explain. ______________________________

How do you think your child will react to this visit?
__Very poorly __Poorly __Well __Excellent __ I don't know

Please provide any further comments or concerns:

____

____

____

____

____

I, ______________________________, give consent for general treatment by Michael Kasselian, D.D.S:
Print name

____
Signature Date

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Patient's Name: ______________________________

History of Allergies: (Please place a check mark on any that apply & circle yes or no.)

- ☐ Latex — yes — no
- ☐ Epinephrine — yes — no
- ☐ Sulfite - Sulfur — yes — no
- ☐ Methylparaben — yes — no
- ☐ Medications: — yes — no
- ☐ Other Allergies: — yes — no

If yes to any of the above please specify.

____

____

______________________________ ______________

Parent Signature Date

Thank you very much for your assistance and cooperation on completing the above form.

Fort Lee Pediatric Dental

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Michael Kassellan, DDS,Specialty #5142
Fort Lee Pediatric Dental Associates, Pa (201) 94 7-5437, Dentistry For Children & Adolescents

Patient's Dental Information - Patient's Name:______________________________

Primary Info:

Insured Name / Date of Birth:____
Insured's Social Security #:____
Insured's Telephone #(*If different from patients): ______________________
Dental Insurance Company Name: ____________________________________
Dental Insurance ID #: ____
Dental Insurance Group#: ____

Secondary Info:

Insured Name / Date of Birth:____
Insured's Social Security #:____
Insured's Telephone #(*If different from patients): ______________________
Dental Insurance Company Name: ____________________________________
Dental Insurance ID #: ____
Dental Insurance Group#: ____

At Dr. Kassellan's office, we provide quality personalized care. The doctor/patient relationship is precious. No third party should interfere in this relationship. An insurance company should not dictate treatment. Regardless of your coverage, we will suggest the care that is appropriate of your child. You will be involved in the treatment planning process.

Ultimately, you are financially responsible for the cost of this care, even if we participate in your insurance plan. Any services that are not covered by your insurance are your responsibility. If we do not participate in your insurance plan, you will pay the doctor and your insurance plan will reimburse you the extent of your coverage.

**** In Dr. Kassellan's office, we do not use amalgam (silver) fillings. We only restore teeth with composite (white) fillings.

If your insurance benefits have been determined prior to treatment, we will wait for the insurance to come directly to us. The patient must pay a co-payment / co-insurance / deductible (if any) at the time of the treatment.

After 60 days from the time of service all balances must be paid in full if your insurance company has not done so. Your insurance company is a third party payer and responsible only to the insured. Therefore, you must take an active role in seeing to it that your insurance company pays the doctor before 60 days elapse. Should this result in an overpayment; the doctor will refund it to you.

Any balances 30 days past due are subject to 1.5% per month late payment charges.

I understand and agree to the above terms.
Signature of parent or guardian:______________________________________

Date signed ______________________________

FORT LEE PEDIATRIC DENTAL ASSOCIATES PA
MICHAEL KASSELIAN, DDS
DENTISTRY FOR CHILDREN AND ADOLESCENTS

Our Office Policy

To Our Valued Patients and Parents:

This year marks the beginning of many exciting changes in our office in our efforts to improve services and quality of care for you so that your children can regain and maintain their dental health as quickly, efficiently and inexpensively as possible.

We have a personal, professional, and ethical responsibility to care for your children's teeth to the best of our ability. Missed appointments and failure to comply with recommended treatment schedules and / or procedure prevent us from achieving our goal of optimum dental health. Therefore, the following polices must be agreed upon:

1. **No Shows are not acceptable** : Failure to make an appointment not only compromises your child's dental health but inconveniences other patients who may have requested an office visit during your scheduled appointment. If you cannot keep an appointment you are expected to call at least 24 hours prior to your appointment to reschedule. There is a minimum of $75.00 fee for all no show appointments and all appointments cancelled without giving proper notice. This fee is not covered by insurance.
2. **Timeliness is required** : We will see you on time and get you in out on time unless there is an emergency. We request that you be on time for your children visit. If you are more than 15 minutes late, you may have to reschedule your appointment.
3. **Cleanliness and Infection control are of the utmost importance** : We have the latest sterilization technology and disinfect each treatment room after every patient. This is another important reason we demand timeliness of you and ourselves.
4. **If you miss an appointment you must make it up** : It is critical to your children's dental health to do so to avoid setbacks in the care and maintenance of their teeth and gums.
5. **We run a zero balance office** : Therefore all payments, insurance co-payments, and deductible are due at the time of service. Please speak to the office manager if you have any questions regarding financing.
6. **We appreciate your referrals.**
7. It is our office policy to ensure the complete satisfaction of all our patients with the service and care they receive at our office. However it is possible on occasion that there may be a misunderstanding or miscommunication between you and our office. We will do everything in our power to make things right for you should an upset occur, provided you bring it to our attention in an appropriate, manner at a time that we can give the matter the proper attention it deserves for effective resolution. You can expect that our staff will treat you with the same manner to resolve immediately any upsets you may have.

We greatly appreciate your cooperation.

Yours in Health,
Dr. Kasselian and Staff of Fort Lee Pediatric Dental Associates

Print Name / **Sign Name and Date**