Patient name ____ Male________ Female________

(First) (M.I.) (Last) Nickname ____________________________

Birthdate______________ Age___________ Phone# ______________ SS#__________________________

Address____

street city/state zip

*****Please Complete Fully*****

Father's Name______________________________	Mother's Name______________________________
Address: ___________________________ Apt.#_____	Address: ___________________________ Apt.#_____
City/State/Zip: ____________________________	City/State/Zip: ____________________________
Phone#:_______________ Cell#__________________	Phone#:_______________ Cell#__________________
Birthdate:_____________ SS#: __________________	Birthdate:_____________ SS#: __________________
Drivers license #____________________________	Drivers license #____________________________
Employer:_________________ Phone:______________	Employer:_________________ Phone:______________
Address: ____________________________________	Address: ____________________________________
Does this employer provide dental insurance for your child?	Does this employer provide dental insurance for your child?
☐ Yes ☐ No If yes, name of dental insurance	☐ Yes ☐ No If yes, name of dental insurance
company______________________________________	company______________________________________
Insurance ID#_________________ Group#___________	Insurance ID#_________________ Group#___________

*****Be sure to list anyone else carrying insurance on child*****

Other (specify relationship)____________________	Other (specify relationship)____________________
Name:_______________________________________	Name:_______________________________________
Address: ___________________________ Apt.#_____	Address: ___________________________ Apt.#_____
City/State/Zip: ____________________________	City/State/Zip: ____________________________
Phone#:_______________ Cell#__________________	Phone#:_______________ Cell#__________________
Birthdate:_____________ SS#: __________________	Birthdate:_____________ SS#: __________________
Drivers license #____________________________	Drivers license #____________________________
Employer:_________________ Phone:______________	Employer:_________________ Phone:______________
Address: ____________________________________	Address: ____________________________________
Does this employer provide dental insurance for your child?	Does this employer provide dental insurance for your child?
☐ Yes ☐ No If yes, name of dental insurance	☐ Yes ☐ No If yes, name of dental insurance
company______________________________________	company______________________________________
Insurance ID#_________________ Group#___________	Insurance ID#_________________ Group#___________

*Nearest relative not living with you________________________________ Phone#__________________

*How did you hear about us? ____

PATIENT MEDICAL HISTORY

Patient's name______________________ ____Age_________

(First) (M.I.) (Last)

Birthdate____________________________________Male______Female______ (Please **circle** response)

Is your child in good health?	No	Yes
Has your child had a serious illness, hospitalization or surgery?	No	Yes
Please explain____		
Does your child have a **blood disorder** or does a **family history exist**?	No	Yes
Please explain____		
Has your child had **Rheumatic Fever?**	No	Yes
Does your child have **Rheumatic Heart Disease?**	No	Yes
Does your child have a heart condition?	No	Yes
Please explain____		
Is your child taking any drugs or medicines?	No	Yes
If so, what and why?____		
Is your child allergic to any medicines?	No	Yes
If so, what?____		
Does your child have any other allergies?	No	Yes
If so, what?____		
Has your child ever had a blood transfusion?	No	Yes
If so, why?____		
Is your child physically handicapped in any way?	No	Yes
If so, in what way? ____		

Does child have a history of: (if yes, please **circle)**

Latex Allergy	Heart Murmur	Shunt
Asthma/RAD	Vision Impairment	Bleeding or Clotting Problems
Diabetes	Down Syndrome	HIV Positive/AIDS
ADHD/ADD	Cleft Lip or Palate	Seizures
Kidney Problems	GERD/Reflux Disease	Eating Disorders
Hepatitis/Liver Problems	Tuberculosis	Emotional and Mental Disorders
Mental Retardation	Learning Disabled	Delayed Development
Autism	Hearing Impairment	Other________________________

Child's Physician ____Phone_______________________

Last physical exam___________________ (Please **circle** response)

Is this your child's first visit to a dentist?	No	Yes
Has your child had any unfavorable dental experiences?	No	Yes

If so, what?____

List any information concerning your child that will help us in seeing him or her ___________________________

____

Have you seen any of our doctors before?____

How far do you drive to come to see us?____

Purpose of today's visit ____

Does your child have any hobbies or special interests?____________________________________

Dog?____________Cat?____________Etc.____

Does your child have any brothers or sisters? If so, how many?______________________________

Broken Appointment Policy

A broken appointment is when a patient fails to give 24 hours notice of cancellation or simply does not show up for an appointment. After two broken or cancelled appointments we will send the parent a warning letter. This letter states that any further broken appointments may result in the patient being dismissed from the practice.

If a third appointment is broken, the parent may receive a letter of dismissal. This letter will give the parent 30 days to establish with a new dentist of his/her choice. Within those 30 days we will be available for any consultation or dental emergency.

CONSENT FOR TREATMENT

I ________________________________give my consent for ____________________________ to be treated by Sylvania Pediatric Dental Care, Inc. If I choose to send my child / children by themselves to our office I have, in fact, given consent for the planned treatment. I will also allow professional judgment in adjusting treatment as necessary to meet the needs of my child / children.

____

(Parent or Guardian Signature) (Date)

After Hours Emergency Call:
419-882-7187 and Call Number Indicated

Visit us at www.SylvaniaKidsDental.com

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

Patient Name____

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

____

(Please print your name)

___________________________________ ___________________________

(Your Signature) (Date)

____

(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)

FINANCIAL OFFICE POLICY

If your account shows a balance you will receive a statement each month, even if insurance has been submitted for you. All fees incurred with this office for services rendered will be due at time of service unless previous arrangements have been made. If for any reason the bill is still outstanding after 60 days a late charge will added to your balance in the amount of 1 ½% per month which is an annual rate of 18%.

INSURANCE: We will be happy to complete and file your insurance forms to aid you in collecting full benefits according to your insurance plan. Patients who have dental insurance should be advised that the professional services rendered are charged to the patient and not the insurance company. You are responsible for any portion not paid by your insurance company, including any co-payments, deductibles, fees over your insurance company's UCR, etc. Even though an insurance claim has been filed, you **will** receive a statement each month if your account has a balance due. It helps us get **your** full benefits if you list complete dental insurance information on the previous page for all insurance plans.

RESPONSIBILITY: We realize that many families are in a state of change. Divorced, separated, single-parent, and blended families are now common. In many of these families the question of who is responsible for the child's dental bills is uncertain. In the case of separated or divorced families we will need to have this form signed by the financially responsible party, otherwise the accompanying parent is responsible.

If you have any questions, please feel free to discuss them with the receptionists.

I have read the office policy and request that your office provide dental care for:

____

(Child's name)

I authorize release of any information relating to any insurance claims. I hereby authorize payment directly to the dentist of the insurance benefits otherwise payable to me.

I understand that by signing this form I am hereby accepting responsibility for any and all fees incurred with this office.

Signature:____Date:____________

Relationship to child:____

Any amendments to this agreement must be discussed with the office manager and another form signed **BEFORE** any services are rendered. No handwritten amendments to this form will be accepted.

Primary family email:____

Please provide us with your email address and we will issue you a secure User ID and password. With this service, you can view your account information, check appointment dates/times and allow us to send you email appointment reminders.