Year:

Patient Name_____ Birthdate_____
Patient Resides with: u Mother u Father u Both u Other_____
Primary family e-mail for appointment confirmations

Father's Name_____ Date of Birth_____
Address_____
(street address) (City) (State) (Zip)
Home Phone_____Work Phone_____Cell Phone_____
Place of Employment_____SS#_____
Does This Employer Provide Dental Insurance Coverage For Your Child? u YES u NO
If Yes, Name of Dental Insurance Company _____ID#_____

Mother's Name_____ Date of Birth_____
Address_____
(street address) (City) (State) (Zip)
Home Phone_____Work Phone_____Cell Phone_____
Place of Employment_____SS#_____
Does This Employer Provide Dental Insurance Coverage For Your Child? u YES u NO
If Yes, Name of Dental Insurance Company _____ID#_____

Other Insured's Name_____ Date of Birth _____
Relationship To Patient_____
Address_____
(street address) (City) (State) (Zip)
Home Phone_____Work Phone_____Cell Phone_____
Place of Employment_____SS#_____
Does This Employer Provide Dental Insurance Coverage For Your Child? u YES u NO
If Yes, Name of Dental Insurance Company _____ID#_____

Broken Appointment Policy of Sylvania Pediatric Dental Care, Inc.

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.
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.

(Parent or Guardian Signature) (Date)

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

Visit us on the World Wide Web:
wwwSylvaniaKidsDental.com