

Patient name _____		Male _____	Female _____
(First) _____	(M.I.) _____	(Last) _____	Nickname _____
Birthdate _____	Age _____	Phone# _____	SS# _____
Address _____		_____	_____
street		city/state	zip

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

Father's Name: _____ Address: _____ Apt.# _____ City/State/Zip: _____ Phone#: _____ Cell# _____ Birthdate: _____ SS#: _____ Drivers license # _____ Employer: _____ Phone: _____ Address: _____ Does this employer provide dental insurance for your child? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of dental insurance company _____ Insurance ID#: _____ Group # _____	Mother's Name: _____ Address: _____ Apt. # _____ City/State/Zip: _____ Phone#: _____ Cell# _____ Birthdate: _____ SS#: _____ Drivers license # _____ Employer: _____ Phone: _____ Address: _____ Does this employer provide dental insurance for your child? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of dental insurance company _____ Insurance ID#: _____ Group # _____
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**\*\*Be sure to list anyone else carrying insurance on child.\*\***

Other (specify relationship) _____ Name: _____ Apt.# _____ Address: _____ City/State/Zip: _____ Phone#: _____ Cell# _____ Birthdate: _____ SS#: _____ Drivers license # _____ Employer: _____ Phone: _____ Address: _____ Does this employer provide dental insurance for your child? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of dental insurance company _____ Insurance ID#: _____ Group # _____	Other (specify relationship) _____ Name: _____ Apt.# _____ Address: _____ City/State/Zip: _____ Phone#: _____ Cell# _____ Birthdate: _____ SS#: _____ Drivers license # _____ Employer: _____ Phone: _____ Address: _____ Does this employer provide dental insurance for your child? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, name of dental insurance company _____ Insurance ID#: _____ Group # _____
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\*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 problem? 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? \_\_\_\_\_

# Sylvania Pediatric Dental Care

## 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 on the World Wide Web: [www.SylvaniaKidsDental.com](http://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 are 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:

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(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: \_\_\_\_\_

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 reminders.