

Date _____

Child Information

Name _____

Last First MI Nickname

Birth date: ____ / ____ / ____ Age: ____ SS#: _____

- Female
- Male

Address _____

Street Apt #

City State Zip

Home Phone#: () _____ - _____ Email Address: _____

School: _____ Grade: _____

Interests/Hobbies/Sports: _____

How did you hear about our office? Yellow Pages Newspaper
 Radio Another Patient? If so who? _____
 Other, please list _____

Parent Information

Mother's Name: _____

Last First MI

Address: _____

(If different from patient) City State Zip

Mother's SS# _____ Birth Date: ____ / ____ / ____

Home#: () _____ - _____ Wk#: () _____ - _____ ext _____

Mother's Employer: _____

How long at job? _____ Job Title: _____

Father's Name: _____

Last First MI

Address: _____

(if different from patient) City State Zip

Father's SS#: _____ Birth date: ____ / ____ / ____

Home#: () _____ - _____ Wk#: () _____ - _____ ext _____

Father's Employer: _____

How Long at job? _____ Job Title: _____

Who is responsible for making child's appointments?

- Mother
- Father

**For patients with insurance -We will file your claim at no charge and accept assignment of benefits from your primary carrier only. For those who have secondary insurance, we will file your claim and make benefits payable to the insured.

Dental Insurance Information

Insured's Name: _____ Relation: _____

Address _____

Street Apt #

City State Zip

Insured's Birth date: ____ / ____ / ____

Insured's SS#: _____

Insured's Employer: _____

Insurance Co. Name: _____

Dental History

Previous Dentist's Name: _____

Date of last dental visit: _____

Has the child experienced problems with previous dental work? No Yes, If so explain _____

Has child ever experienced an injury to mouth, teeth, or jaw? No Yes, If so explain _____

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ / TMD)? No Yes

Does the child brush his/her teeth daily? No Yes

Floss his/her teeth daily? No Yes

Does/Did child have braces? No Yes

Does/ Did child have any of the following habits? (Check boxes that apply to child):

- Clenching/Grinding Teeth
- Lip Sucking/ Biting
- Nail Biting
- Nursing Bottle Habits
- Speech Problems
- Thumb/ Finger Sucking

Has your child ever had sealants placed? _____

On a scale of 1-10 (10 being highest) How important is your child's dental health to you? _____

Do you think it is important to have your child's teeth cleaned every 6 months? _____

What is most important about your relationship with Dr. Baluyut?

Medical History

Does child have a personal physician? Yes No

Physician's Name: _____

Address: _____
Street

City _____ State _____ Zip _____

Phone#: () _____ - _____ Date of last visit: _____

Please describe Child's Current Physical Health:
 Good Fair Poor

Is child currently under the care of a physician? Yes No

If yes, for what conditions: _____

Has child ever responded adversely to medical treatment? _____

Is child taking any medication at this time? Yes No

If yes, please list _____

Does child have any drug allergies or has ever had an adverse reaction to any medication? No Yes If so, list names of medications _____

Is there anything else we should know about your child's medical history? No Yes If so, explain: _____

Are child immunizations current? No Yes

Does child have or ever had any of the following?
(Check boxes that apply to child).

- | | |
|---|---|
| <input type="checkbox"/> A.I.D.S./ HIV | <input type="checkbox"/> Hearing Impairment |
| <input type="checkbox"/> ADD/ ADHD | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Allergies to Anesthetics | <input type="checkbox"/> Heart Problems |
| <input type="checkbox"/> Allergies to Latex | <input type="checkbox"/> Hemophilia |
| <input type="checkbox"/> Allergies to Medicines | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Artificial Heart Valves | <input type="checkbox"/> Jaundice |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Kidney /Liver Problems |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Radiation Treatment |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Respiratory Disease |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Sickle Cell Disease/Traits |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> General Allergies | <input type="checkbox"/> Special Diet |
| | <input type="checkbox"/> Tuberculosis (TB) |

Office Information

APPOINTMENTS:

Please understand that it is important for you to keep your child's scheduled dental appointments to maintain optimal dental health. Postponing treatment could compromise the child's condition resulting in discomfort and additional costs.

The child's appointment time is set-aside especially for him/her. We strive to stay on time and ask you to be on time for his/her appointments. We ask that if you have a change in your schedule and wish to change his/her appointment, please contact us 48 hours in advance so that we can schedule another appointment for him/her as soon as possible and make your time available to another patient waiting for an appointment.

Repeated cancellations or broken appointments without a 48-hour notice could result in a broken appointment charge or no reappointment.

PAYMENT:

We have several payment options available to you. These options are described in length on our Financial Menu. Please ask if you have any questions.

We realize that many families are in a state of change. The policy in our office is the parent who presents with the patient for treatment is responsible for payment.

INSURANCE:

We will file your claim for you at no charge. We will estimate a portion that insurance typically pays with the understanding that your plan could pay more or less. Any difference between our estimate and the amount actually paid is due from the patient. We will inform you of this amount.

BILLING:

We have established a financial menu aimed at trying to keep billing costs to a minimum. For patients with balance after insurance, payment is due within 60 days. A 1-1/2% monthly finance charge will be added to all balances that are 60 days overdue.

Patient Consent & Authorization

I affirm that the above information I have given is correct to the best of my knowledge and will be used for treatment, billing, and processing of insurance claims. I will not hold my dentist or any staff member responsible for any omissions or errors that I may have made in the completion of this form. I understand that it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary services that my child may need. I assign the Doctor all insurance benefits. I understand that I am responsible for all costs of dental treatment or any services rendered.

Parent Signature _____ Date _____

Office Use Only

I reviewed the medical/dental information of this patient named here in.

Date _____ Signature _____

Patient ID # _____