Southridge Pediatric Dentistry

Child's Name:_____Nickname:_____

Home Phone:_____Age:_____ Birthdate:_____ ☐ Male ☐ Female

Email Address:_____

Address:_____

Apartment #

_____

City State Zip Code

Father or Guardian:_____ Social Security Number:_____

Home Phone:_____ Cell Phone:_____ Birthdate:_____

Employer:_____ Work Phone:_____

Mother or Guardian:_____ Social Security Number:_____

Home Phone:_____ Cell Phone:_____ Birthdate:_____

Employer:_____ Work Phone:_____

Marital Status of Parents (check one): ☐ Married ☐ Single ☐ Divorced ☐ Widowed ☐ Separated

DENTAL HISTORY:

Date of Last Dental Visit:_____ Reason for this Visit:_____

How often does your child brush?_____ Floss?_____

Does your child use a pacifier or suck a thumb or finger?_____

Please describe how you think your child will behave today. Check all that apply.

☐ Friendly ☐ Cooperative ☐ Happy ☐ Anxious ☐ Timid ☐ Afraid ☐ Resistant

MEDICAL HISTORY:

Name of Physician:_____ Phone:_____

Is your child currently taking any medication? If yes, what?_____

Is your child allergic to any medications? If yes, what?_____

Has your child ever been hospitalized? If yes, what?_____

Is your child currently under a physician's care? If yes, why?_____

Has your child ever had any of the following? Please check **Yes** or **No**:

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	AIDS or HIV	☐	☐	Cleft Palate/Lip	☐	☐	Heart Murmur	☐	☐	Reaction to Medication
☐	☐	Allergies_____	☐	☐	Cystic Fibrosis			Last Echo:_____	☐	☐	Respiratory Treatment
☐	☐	Anemia	☐	☐	Deaf	☐	☐	Heart Surgeries	☐	☐	RSV
☐	☐	Arthritis	☐	☐	Diabetes	☐	☐	Hepatitis	☐	☐	Seizures
☐	☐	Artificial Joints	☐	☐	Down Syndrome	☐	☐	Jaundice	☐	☐	Shunt
☐	☐	Asthma	☐	☐	Ear Problems-Tubes	☐	☐	Kidney Disease	☐	☐	Spina Bifida
☐	☐	Autism	☐	☐	Epilepsy	☐	☐	Latex Allergy	☐	☐	Stomach Problems
☐	☐	Birth Defects	☐	☐	Excessive Bleeding	☐	☐	Liver Disease	☐	☐	Tuberculosis
☐	☐	Blood Disease	☐	☐	Facial Injuries	☐	☐	Mental Disorders	☐	☐	Vomiting - Excessive
☐	☐	Blood Transfusions	☐	☐	Glaucoma	☐	☐	Osteogenisis Impefecta	**OTHER:**		
☐	☐	Cancer	☐	☐	Hay Fever	☐	☐	Pacemaker	_____		
☐	☐	Cerebral Palsy	☐	☐	Head Injuries	☐	☐	Radiation Treatment	_____		
			☐	☐	Heart Problems	☐	☐	Reactive Airway Disease	_____		

Any Additional Concerns / Comments:_____

_____

Southridge Pediatric Dentistry

REFERRAL INFORMATION:

Whom may we thank for referring you to our practice? ☐ Another Patient, Friend ☐ Another patient, Relative ☐ Dental Office ☐ Internet ☐ Insurance List ☐ Other:_____

Name of person or office referring you to our practice:_____

PERSON FINANCIALLY RESPONSIBLE:

Name:_____

Relationship to patient:_____ Home Phone:_____ Work Phone:_____

Address (if different):_____ City, State, Zip:_____

Birthdate:_____ Social Security Number:_____ Employer:_____

Name of nearest relative not living with you:_____ Phone:_____

PRIMARY DENTAL INSURANCE COMPANY:

Name:_____

Address:_____

City, State, Zip:_____

Phone:_____ Group #:_____

Insured person's name:_____

ID number:_____

SECONDARY INSURANCE COMPANY:

Name:_____

Address:_____

City, State, Zip:_____

Phone:_____ Group #:_____

Insured person's name:_____

ID number:_____

PAYMENT IN FULL IS EXPECTED AT TIME OF TREATMENT

Method of payment (Please Check One):

☐ Check or Cash at Time of Service ☐ Insurance Co-Payment at Time of Service ☐ Credit Card ☐ Payment Plan Option

THE RESPONSIBLE PARTY AGREES TO:

- All first time patients are required to pay in full at time of treatment unless insurance is being utilized.
- Patients with insurance must pay their estimated portion, including deductibles at time of service unless prior arrangements have been made with office staff.
- Please note that we submit insurance claims as a courtesy, it is the parent's/guardian's responsibility to see that the insurance company makes prompt payment.
- I agree to pay for the balance of treatment that is not covered by the insurance company.
- Any insurance balance over 60 days is due and payable by the parent/legal guardian.
- I agree to pay the balance within 90 days (unless payment options have been arranged with the office staff) or the account will be turned over to an outside collection agency.
- I grant permission to the dentist to perform any necessary dental work for this child.
- Pay the doctor at the time of service for treatment rendered.
- Pay all costs of collection agency commission, court and attorney's fees (can be up to 40% of unpaid balance).
- Pay an interest rate of 1 ½% per month (18% per annum) for unpaid balances over 60 days. Personal credit checks.
- Your appointment time in our office is reserved to you, because you are important to us. A $25.00 fee will be charged for appointments canceled, missed or rescheduled without 24 hours notice. Dismissal from our practice after 2 missed appointments.
- Pay $20.00 for all returned checks.
- I authorize release of any information in the course of the examination or treatment of the dentist.
- Authorize payment to medical/dental benefits to the undersigned dentist for services described.
- I understand that as a parent/legal guardian bringing in my child, I am legally responsible for the payment of all fees.

Signature of Authorized Person:_____ **Date:**_____