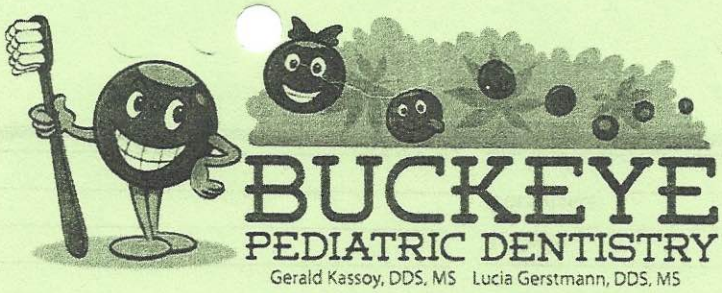

BUCKEYE PEDIATRIC DENTISTRY

Gerald Kassoy, DDS, MS Lucia Gerstmann, DDS, MS
1418 Brice Rd. Suite 203 Reynoldsburg, Ohio 43068
p 614-575-2225 f 614-575-2252

Tell Us About Your Child

Today's Date: _____

Child's Name: _____

Nickname: _____ ☐ Male ☐ Female

Child's Birthdate: ____/____/____ Child's Age: _____

School: _____

Child's Home #: (___)_____ SS#: _____

Child's Home Address:

_____

_____

Who is Accompanying the Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we Thank for referring you? _____

Other family members seen by us: _____

Previous/Present Dentist: _____

Last Visit Date: _____

Parent's Marital Status: ☐ Single ☐ Widowed

☐ Married ☐ Divorced ☐ Separated

Mother's Information: SS#: _____

Name: _____ Birthdate: __/__/__

Cell : (___)_____ Wk # (___)_____

Employer: _____

Email : _____

Father's Information: SS#: _____

Name: _____ Birthdate: __/__/__

Cell : (___)_____ Wk # (___)_____

Employer: _____

Email : _____

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local, or Policy#): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: __/__/__ SS#: _____

Policy Owner's Employer: _____

Orthodontic Coverage? ☐ Yes ☐ No

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: (____)_____

Group # (Plan, Local, or Policy#): _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: __/__/__ SS#: _____

Policy Owner's Employer: _____

Orthodontic Coverage? ☐ Yes ☐ No

What is the best way to be contacted?

☐ **Cell Phone** ☐ **Home Phone** ☐ **Email**

Patient Name: _____

Why did you bring your child to the dentist today?

_____

_____

Has the child ever had a serious/difficult problem as associated with previous dental work? ☐Yes ☐ No

Is the child's water fluoridated? ☐Yes ☐ No

Is the child taking fluoride supplements? ☐Yes ☐ No

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

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

Floss his/her teeth daily? ☐Yes ☐ No

Child's physician: _____

Phone #: _____ Date of last visit: _____

Pharmacy # _____

Please describe the child's current physical health:

☐Good ☐ Fair ☐ Poor

_____

Please list all drugs that the child is currently taking:

_____

_____

Please list all drugs/materials that the child is allergic to: _____

_____

Has the child ever had any of the following medical problems?

Y N Autistic Spectrum Disorder

Y N Abnormal Bleeding

Y N Allergies to any Drugs

Y N Any Hospital Stays

Y N Any Operations

Y N Asthma

Y N Cancer

Y N Congenital Heart Defect

Y N Convulsions/Epilepsy

Y N Diabetes

Y N Handicaps/Disabilities

Y N Hearing Impairment

Y N Heart Murmur

Y N Hemophilia

Y N Hepatitis

Y N HIV+/AIDS

Y N Kidney/Liver Problems

Y N Rheumatic/Scarlet Fever

Y N Tuberculosis

Please discuss any serious medical problems that the child has had: _____

_____

_____

Does the child have any of the following habits?

Y N Lip Sucking/Biting

Y N Nail Biting

Y N Nursing Bottle Habits

Y N Thumb/Finger Sucking

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest confidence and it is my responsibility to inform the office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of parent or guardian **Date**

OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY • OFFICE USE ONLY

I verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

Initials: _____ Date: _____

Doctor's Comments: _____

_____

_____

_____

Medical History Update

1. Date: _____ Signature: _____

Comments: _____

_____

2. Date: _____ Signature: _____

Comments: _____

_____

Buckeye Pediatric Dentistry, Insurance & Financial Policy

We are committed to providing your child with the best possible dental care. That's why we always present you with the best dental solution possible to treat your child's personal situation. Each year we provide outstanding dental care to hundreds of children. Some have dental benefits but some don't. If you have dental benefits, congratulations! You are very fortunate. Here are some important things you should know...

Your dental benefits are based upon a contract made between your employer and an insurance company. **If you have questions regarding your dental benefits please contact your employer or insurance company directly. Dental benefit plans normally don't pay for all of your dental care. It is only meant to assist you.**

We bill your insurance as a courtesy. If insurance does not pay within 90 days, we reserve the right to request payment in full for services from you and let you collect the insurance funds that are due to you. This is rare but it is important that you recognize that the insurance you have is a legal contract between YOU and your insurance company. Ultimately, you are responsible for all charges incurred in our office.

Our office does require payment in full for your portion at the time of service. We accept MasterCard, Visa, cash and checks. If you are in need of an extended finance option, we also work with Care Credit, who offers "same as cash" financing or longer terms with an interest bearing revolving charge designed to meet your treatment plan needs on approved credit. You can obtain more information about Care Credit by visiting their website, www.carecredit.com or simply asking one of our office staff for an application.

The collection company that our office works with requires guarantor social security numbers, if you choose to **NOT** provide our office with your personal data you will be considered a **" Fee for service"** patient which means you'll have to pay for your child's visits on the day of service and your insurance company will reimburse you directly.

Broken Appointments: A specific amount of time is reserved especially for your child and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at **least 24 hours** notice to avoid a **$25 fee for each appointment that was broken.**

We welcome you to our family and look forward to helping you get the healthy, beautiful smile you've always wanted. If there is anything we can do to make you visits here more pleasant, please don't hesitate to ask one of our staff members.

Print Name:_____

Signature & Date:_____

I acknowledge that I have received a notice of privacy practices from the above named practice.

Patient Name:_____

Parent/Guardian Signature:_____
Relationship to Patient:_____