

Appointment Date: \_\_\_\_\_

### Patient Information

Patient Name: \_\_\_\_\_ Preferred name: \_\_\_\_\_  Male  Female  
Last First  
Birthdate: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Phone (Home): \_\_\_\_\_ (Cell): \_\_\_\_\_  
Preferred Contact E-Mail Address: \_\_\_\_\_  
Address: \_\_\_\_\_  
Street Unit or Apartment #  
City State Zip Code

### Health Information

Date of your child's last dental visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

Has your child ever had any of the following? Please check those that apply:

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Allergy - Latex    | <input type="checkbox"/> Asperger Syndrome | <input type="checkbox"/> Hepatitis            |
| <input type="checkbox"/> Allergy - Food     | <input type="checkbox"/> Asthma            | <input type="checkbox"/> High Blood Pressure  |
| _____                                       | <input type="checkbox"/> Autism            | <input type="checkbox"/> HIV Positive         |
| <input type="checkbox"/> Allergy - Drug     | <input type="checkbox"/> Blood Disorder    | <input type="checkbox"/> Jaundice             |
| _____                                       | <input type="checkbox"/> Cancer            | <input type="checkbox"/> Kidney Disease       |
| <input type="checkbox"/> Allergy - Seasonal | <input type="checkbox"/> Cerebral Palsy    | <input type="checkbox"/> Liver Disease        |
| _____                                       | <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Radiation Treatment  |
| <input type="checkbox"/> Allergy - Other    | <input type="checkbox"/> Down Syndrome     | <input type="checkbox"/> Respiratory Problem  |
| _____                                       | <input type="checkbox"/> Eye Condition     | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Head Injuries     | <input type="checkbox"/> Rheumatoid Arthritis |
| <input type="checkbox"/> Apraxia            | <input type="checkbox"/> Heart Disease     | <input type="checkbox"/> Sensory Issues       |
|   | <input type="checkbox"/> Heart Murmur      | <input type="checkbox"/> Sinus Problems       |
|   |  | <input type="checkbox"/> Seizures             |
|   |  | <input type="checkbox"/> Other _____          |

• Has your child ever had any complications following dental treatment?  Yes  No

If yes, please explain: \_\_\_\_\_

• Has your child been admitted to a hospital or needed emergency care during the past two years?  Yes  No

If yes, please explain: \_\_\_\_\_

• Is your child now under the care of a physician?  Yes  No

If yes, please explain: \_\_\_\_\_

• Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

• List any medications your child is taking: \_\_\_\_\_

• Does your child have any health problems that need further clarification?  Yes  No

If yes, please explain: \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my child's health, I will inform the doctors at the next appointment without fail.

Signature of parent or guardian

Date

### Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative

Dental Office  Pediatrician  Advertising  School  Work  Other \_\_\_\_\_

Name of person or office referring you to our practice: \_\_\_\_\_

### Parent or Guardian Information

**FATHER:** \_\_\_\_\_  Married  Single  Other

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_

Address (if different from child): \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

**MOTHER:** \_\_\_\_\_  Married  Single  Other

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ (Cell): \_\_\_\_\_

Address (if different from child): \_\_\_\_\_

Employer Name: \_\_\_\_\_ Occupation: \_\_\_\_\_

### Primary Insurance Information

Policy Holder's Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date \_\_\_\_\_

Insurance Carrier Name: \_\_\_\_\_

Contract ID #: \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

Policy Holder's Address (if different from child): \_\_\_\_\_

### Secondary Insurance Information

Policy Holder's Name: \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date \_\_\_\_\_

Insurance Carrier Name: \_\_\_\_\_

Contract ID #: \_\_\_\_\_ Group # \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_

Policy Holder's Address (if different from child): \_\_\_\_\_

### Consent for Services and Guarantor Agreement

As a condition of your child's treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patients insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

In consideration of the professional services rendered by Doctor Jarmoszuk on my child, I agree to pay Doctor Jarmoszuk, or her assignee, the reasonable value of those services at the time they are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of the services rendered shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and fees, including reasonable attorneys' fees, associated with the collection of any amounts past due related to the services rendered on my child.

I grant my permission to you or your assignee, to contact me or leave messages for me by any of the above means (address, home phone, work phone, cell phone, e-mail, or text) to discuss matters related to this form.

I have read the above conditions of treatment and payment and agree to their content.

\_\_\_\_\_  
Signature of parent, guardian and/or responsible party

\_\_\_\_\_  
Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_