Patient Information

Patient Name: _____ Date _____
Last First MI (Preferred Name)

Age: _____ Birthdate: _____ Gender: _____ Adopted: _____ SS #: _____

Attends what school: _____ Grade: _____

Names & ages of brothers & sisters: _____

Child's physician or pediatrician: _____

Dental History

- Is your water supply fluoridated? ☐ Yes ☐ No _____
- Is this your child's first visit to the dentist? ☐ Yes ☐ No _____
- Has your child had a toothache recently? ☐ Yes ☐ No _____
- Has your child fallen and chipped or bumped any of his teeth? ☐ Yes ☐ No _____
- Has your child had any unfavorable experience in the dental office? ☐ Yes ☐ No _____
- Has your child had a history of thumbsucking, lip or nail biting? ☐ Yes ☐ No _____
- Do you brush your child's teeth? ☐ Yes ☐ No _____

Medical History

- Has your child had a physical exam within the last year? ☐ Yes ☐ No
- Has your child ever been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____
- Is your child taking any medication at this time? Vitamins? ☐ Yes ☐ No
  List: _____
- Any types of Autism or developmental disabilities _____

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

☐ AIDS
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bleeding Disorder
☐ Blood Disease
☐ Bronchitis
☐ Cerebral Palsy
☐ Convulsions
☐ Dizziness
☐ Epilepsy
☐ Fainting
☐ Hay Fever
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Pneumonia
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Seizures
☐ Sinus Problems
☐ Stomach Problems
☐ Tuberculosis
☐ Tumors
☐ Ulcers
☐ Aspirin Allergy
☐ Anesthetic Allergy
☐ Codeine Allergy
☐ Penicillin Allergy
☐ Other: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If my child has any change in health, I will inform the doctors at the next appointment.

Referral Information

Whom may we thank for referring you to our practice: _____

Responsible Party Information

Mother's Name _____ Date of Birth _____

☐ Married ☐ Single ☐ Other Social Security #: _____

Phone (Home) _____ (Work) _____ Ext _____ (Cell) _____

Address _____ City _____ State _____ Zip Code _____

Employer Name _____ Occupation _____

Insurance Carrier _____ Group # _____

Billing Address _____

Carrier Phone # _____ Primary or Secondary _____

Father's Name _____ Date of Birth _____

☐ Married ☐ Single ☐ Other Social Security #: _____

Phone (Home) _____ (Work) _____ Ext _____ (Cell) _____

Address _____ City _____ State _____ Zip Code _____

Employer Name _____ Occupation _____

Insurance Carrier _____ Group # _____

Billing Address _____

Carrier Phone # _____ Primary or Secondary _____

Consent for Services

Your child is a minor, it therefore is necessary that a signed permission be obtained from a parent or guardian before any and/or all necessary dental service can be started and accomplished by Dr. Bozic. Authorization is hereby granted as such.

As a condition of your 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.

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; this 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.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services 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 reasonable attorney fees if suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

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

_____ Date: _____ Relationship to Patient: _____

Signature of guarantor of payment/responsible party