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:

- ☐ **Allergy – Latex**
- ☐ **Allergy – Food** ________________ ________________
- ☐ **Allergy – Drug** ________________ ________________
- ☐ **Allergy – Seasonal** ________________ ________________
- ☐ **Allergy – Other** ________________
- ☐ **Anemia**
- ☐ **Apraxia**
- ☐ **Asperger Syndrome**
- ☐ **Asthma**
- ☐ **Autism**
- ☐ **Blood Disorder**
- ☐ **Cancer**
- ☐ **Cerebral Palsy**
- ☐ **Diabetes**
- ☐ **Down Syndrome**
- ☐ **Epilepsy**
- ☐ **Eye Condition** ________________
- ☐ **Head Injuries**
- ☐ **Heart Disease** ________________
- ☐ **Heart Murmur**
- ☐ **Hepatitis**
- ☐ **High Blood Pressure**
- ☐ **Kidney Disease**
- ☐ **MTHFR Mutation**
- ☐ **Radiation Treatment**
- ☐ **Respiratory Problems**
- ☐ **Rheumatoid Arthritis**
- ☐ **Sensory Issues** ________________
- ☐ **Sinus Problems**
- ☐ **Seizures**
- ☐ **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 for other than well-visits? ☐ Yes ☐ No
If yes, please explain: ____

• Name of Physician or Pediatrician: ____

• 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 15 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.

______________________________ Date: ____________ Relationship to Patient: ______________

Signature of parent, guardian and/or responsible party