

# WELCOME

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 preventative care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

## 1

### Tell Us About Your Child

Today's Date: \_\_\_\_\_  
Child's Name: \_\_\_\_\_  
Last First MI  
Nickname: \_\_\_\_\_  Male  Female  
Child's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ Child's Age: \_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_  
Child's Home #: (\_\_\_\_) \_\_\_\_\_ SS#: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_  
Child's Home Address: \_\_\_\_\_  
City State Zip

## 2

### 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

## 3

### Mother's Information

Stepmother  
 Guardian  
Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Wk #: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_\_  
Employer: \_\_\_\_\_  
SS#: \_\_\_\_\_ DL#: \_\_\_\_\_

### Father's Information

Stepfather  
 Guardian  
Name: \_\_\_\_\_ Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_  
Wk #: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_\_  
Employer: \_\_\_\_\_  
SS#: \_\_\_\_\_ DL#: \_\_\_\_\_

## 4

### Person Responsible for Account

Name: \_\_\_\_\_ Relation: \_\_\_\_\_  
Billing Address: \_\_\_\_\_  
City State Zip  
Home #: (\_\_\_\_) \_\_\_\_\_ DL#: \_\_\_\_\_  
Employer: \_\_\_\_\_  
Wk #: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_ SS#: \_\_\_\_\_  
Who is responsible for making appointments?  
Name: \_\_\_\_\_  
Wk #: (\_\_\_\_) \_\_\_\_\_ Ext. \_\_\_\_ Home #: (\_\_\_\_) \_\_\_\_\_

## 5

### Primary Dental Insurance

Insurance Co. Name: \_\_\_\_\_  
Ins. Co. Address: \_\_\_\_\_  
Ins. Co. Phone #: (\_\_\_\_) \_\_\_\_\_  
Group # (Plan, Local or Policy #): \_\_\_\_\_  
Policy Owner's Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Policy Owner's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_  
Policy Owner's Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
Orthodontic Coverage?  Yes  No

### Secondary Dental Insurance

Insurance Co. Name: \_\_\_\_\_  
Ins. Co. Address: \_\_\_\_\_  
Ins. Co. Phone #: (\_\_\_\_) \_\_\_\_\_  
Group # (Plan, Local or Policy #): \_\_\_\_\_  
Policy Owner's Name: \_\_\_\_\_  
Relationship to Patient: \_\_\_\_\_  
Policy Owner's Birthdate: \_\_\_\_/\_\_\_\_/\_\_\_\_ SS#: \_\_\_\_\_  
Policy Owner's Employer: \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
Orthodontic Coverage?  Yes  No





## Medical History

Patient Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Why did you bring the child to the dentist today? \_\_\_\_\_  
\_\_\_\_\_

Has the child ever had a serious/difficult problem associated with previous dental work?  Yes  No If yes, please explain: \_\_\_\_\_

Is the child's water fluoridated?  Yes  No

Is the child taking fluoridated supplements?  Yes  No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)?  Yes  No If yes, please explain: \_\_\_\_\_

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: \_\_\_\_\_

Is the child currently under the care of a physician?  Yes  No

Please describe the child's current physical health:  Good  Fair  Poor

Is the child allergic to any of the following?

Aspirin  Penicillin  Codeine  Acrylic  Metal  Latex  Local Anesthetics

Other, please explain: \_\_\_\_\_

Does the child have, or had, any of the following?

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Abnormal Bleeding         | <input type="checkbox"/> Convulsions               | <input type="checkbox"/> Heart Pace Maker      | <input type="checkbox"/> Recent Weight Loss         |
| <input type="checkbox"/> ADD/ADHD                  | <input type="checkbox"/> Cortisone Medicine        | <input type="checkbox"/> Heart Trouble/Disease | <input type="checkbox"/> Renal Dialysis             |
| <input type="checkbox"/> AIDS/HIV Positive         | <input type="checkbox"/> Diabetes                  | <input type="checkbox"/> Hemophilia            | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Alzheimer's Disease       | <input type="checkbox"/> Drug Addiction            | <input type="checkbox"/> Hepatitis A           | <input type="checkbox"/> Rheumatism                 |
| <input type="checkbox"/> Anaphylaxis               | <input type="checkbox"/> Easily Winded             | <input type="checkbox"/> Hepatitis B or C      | <input type="checkbox"/> Scarlet Fever              |
| <input type="checkbox"/> Anemia                    | <input type="checkbox"/> Emphysema                 | <input type="checkbox"/> Herpes                | <input type="checkbox"/> Shingles                   |
| <input type="checkbox"/> Angina                    | <input type="checkbox"/> Epilepsy or Seizures      | <input type="checkbox"/> High Blood Pressure   | <input type="checkbox"/> Sickle Cell Disease        |
| <input type="checkbox"/> Arthritis/Gout            | <input type="checkbox"/> Excessive Bleeding        | <input type="checkbox"/> Hives or Rash         | <input type="checkbox"/> Sinus Trouble              |
| <input type="checkbox"/> Artificial Heart Valve    | <input type="checkbox"/> Excessive Thirst          | <input type="checkbox"/> Hypoglycemia          | <input type="checkbox"/> Spina Bifida               |
| <input type="checkbox"/> Artificial Joint          | <input type="checkbox"/> Fainting Spells/Dizziness | <input type="checkbox"/> Irregular Heartbeat   | <input type="checkbox"/> Stomach/Intestinal Disease |
| <input type="checkbox"/> Asthma                    | <input type="checkbox"/> Frequent Cough            | <input type="checkbox"/> Kidney Problems       | <input type="checkbox"/> Stroke                     |
| <input type="checkbox"/> Blood Disease             | <input type="checkbox"/> Frequent Diarrhea         | <input type="checkbox"/> Leukemia              | <input type="checkbox"/> Swelling of Limbs          |
| <input type="checkbox"/> Blood Transfusion         | <input type="checkbox"/> Frequent Headaches        | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Thyroid Disease            |
| <input type="checkbox"/> Breathing Problems        | <input type="checkbox"/> Genital Herpes            | <input type="checkbox"/> Low Blood Pressure    | <input type="checkbox"/> Tonsillitis                |
| <input type="checkbox"/> Bruise Easily             | <input type="checkbox"/> Glaucoma                  | <input type="checkbox"/> Lung Disease          | <input type="checkbox"/> Tuberculosis               |
| <input type="checkbox"/> Cancer                    | <input type="checkbox"/> Handicaps/Disabilities    | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Tumors or Growths          |
| <input type="checkbox"/> Chemotherapy              | <input type="checkbox"/> Hay Fever                 | <input type="checkbox"/> Pain in Jaw Joints    | <input type="checkbox"/> Ulcers                     |
| <input type="checkbox"/> Chest Pains               | <input type="checkbox"/> Hearing Impairment        | <input type="checkbox"/> Parathyroid Disease   | <input type="checkbox"/> Venereal Disease           |
| <input type="checkbox"/> Cold Sores/Fever Blisters | <input type="checkbox"/> Heart Attack/Failure      | <input type="checkbox"/> Psychiatric Care      | <input type="checkbox"/> Yellow Jaundice            |
| <input type="checkbox"/> Congenital Heart Disorder | <input type="checkbox"/> Heart Murmur              | <input type="checkbox"/> Radiation Treatments  |   |

Have you ever had any serious illness not listed above?  Yes  No If yes, please explain: \_\_\_\_\_

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Does/did the child have any of the following habits?

- Lip Sucking/Biting  Nail Biting  
 Nursing Bottle Habits  Thumb/Finger Sucking

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent, or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT FOR TREATMENT**

I hereby authorize doctor or designed staff to take x-rays, study models, photographs, and any other diagnostic aids deemed appropriate by doctor to make a thorough diagnosis of patient’s dental needs. Upon such diagnosis, I authorize the doctor to perform all the recommended treatment mutually agreed upon by me and to employ such assistance as required to provide proper care. I agree to the use of anesthetics, sedatives and other medication as necessary. I fully understand that using anesthetic agents embodies certain risks. I understand that I can ask for a complete recital of any possible complications.

Signature of Patient/Parent/Guardian \_\_\_\_\_ Date \_\_\_\_\_

**FINANCIAL GUIDELINES**

I understand that: 1) Full payment is due at the time of service. 2) **All charges are ultimately the responsibility of the patient/guarantor/ (regardless of insurance).** 3) A third party (with the exception of insurance companies) will not be billed for any amount due to this office. Custodial parents are guarantors for children: this office is not party in domestic settlements. 4) In the event payment is not made by the due date, a late charge fee may be added to the patient’s account. 5) Any collection fees incurred by this office in an attempt to obtain payment, or bank fees for a returned check, or fees for an appointment missed or broken with less than 48 hours notice will be paid by the patient/guarantor.

**ADDITIONAL POLICES PERTAINING TO INSURANCE:**

I understand that: 1) We cannot bill your insurance company unless we are given the correct information. This includes subscriber’s name and date of birth, subscriber’s employer, correct identification number, and mailing address of the insurance company. 2) The patient/guarantor is responsible to pay for all services rendered on the behalf if insurance does not pay within 60 days of date of service. 3) Any deductible and/or co-insurance is due at time of service. 4) **This office is not contracted with any insurance as a networked provider. Therefore, any fee or portion of a fee not covered by insurance is the patient’s/guarantor’s responsibility to pay.** Acceptance of insurance assignment of benefits to this office does not absolve the patient of full responsibility of payment for treatment rendered. Any estimate given by this office regarding insurance portion is only a guideline until guarantee of the insurance payment is received and the patient’s account has been reconciled. **This office makes no guarantee of the insurance payment as estimated.** 5) Any patient/guarantor whose insurance carrier does not honor assignment of benefits to the provider of service must pay this office in full at the time of the services rendered. This office makes no guarantee of the insurance payment as estimated.

**APPOINTMENTS**

Please be courteous and help us serve you better by keeping scheduled appointments. **It is your responsibility to call 48 hours in advance to cancel your appointment.** Your dental care is a team effort and we need your help to keeping your dental health at its best. I certify that I have read and do hereby agree to the above stated information.

Patient \_\_\_\_\_ Date \_\_\_\_\_

Parent or Responsible Party \_\_\_\_\_ Date \_\_\_\_\_





## **Late Cancellation and No-Show Policy**

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We understand that situations arise in which you must cancel a previously scheduled appointment; however, we kindly request that you provide our office with at least 48 hours notice for a cancellation. This is a courtesy that allows us to use that appointment time to serve other patients, especially same day emergency patients.

**Please be advised that there is a possibility of a \$30 fee per ½ hour that is scheduled for your appointment time if not enough notice is given.**

**~ Thank You ~**

To cancel or change your appointment, please call (304) 243-1500

Patient signature \_\_\_\_\_

Witness \_\_\_\_\_

Please be considerate of all our patients, so we can serve everyone properly.

**PATIENT CONSENT FORM**

I understand that I have certain rights to privacy regarding my protected health information.

These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

Treatment (including direct or indirect treatment by other healthcare providers involved in my Treatment).

Obtaining payment from third party payers (e.g. my insurance company)

The day to day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my right under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

Print Patient Name: \_\_\_\_\_

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

Signature: \_\_\_\_\_

Practice Name: Zambito Family Dentistry, PLLC

Address: 1201 Mt De Chantal Road

City/State/Zip Wheeling, WV 26003