Dental Group of Mentor Family Dentistry

WELCOME to our office. Our goal is to make your child's visits to our office pleasant, educational and fun. We practice preventative dentistry and try to pass on good habits that will enable your child to have a happy, healthy smile that will last a lifetime.

Patient's Acct. # _____

OFFICE USE ONLY

Today's Date ____/____/____

Tell Us About Your Child

Child's Name

LAST FIRST MI

Nickname _____ MALE / FEMALE

Child's Birthdate ____/____/____ Age:

School

Social Security #

Child's Home Address

CITY STATE ZIP

Child's Home #

Favorite Toys, Activities:

Who Is With The Child Today?

Name

Relationship

Do you have legal custody of this child? YES / NO

Whom may we thank for referring you?

Other family members seen by us?

Parent's Marital Status: Single / Married / Divorced / Separated / Widowed

Person Responsible For Accont

Name

Relationship

Billing Address

CITY STATE ZIP

Work # Ext.

Home #

Employer

DL# SS#

Who is responsible for making appointments?

Name

Home # Work #

Mother's Information ☐ Step Mother ☐ Guardian

Name

Birthdate ____/____/____

Home # Work #

Employer

DL# SS#

Father's Information ☐ Step Father ☐ Guardian

Name

Birthdate ____/____/____

Home # Work #

Employer

DL# SS#

Primary Dental Insurance

Insurance Co. Name

Group # (Plan, Local, or Policy #)

Policy Owner Name

Relationship to Patient

Policy Owner's Birthdate ____/____/____

Policy Owner's SS#

Policy Owner's Employer

Secondary Dental Insurance

Insurance Co. Name

Group # (Plan, Local, or Policy #)

Policy Owner Name

Relationship to Patient

Policy Owner's Birthdate ____/____/____

Policy Owner's SS#

Policy Owner's Employer

Patient Name: _____ Date: _____

Dental Group of Mentor

Dental History

Child's last dental visit? ____/____/____ For what? _____
Child's attitude towards dentistry? _____
Any habits? (thumb sucking, mouth breathing, pacifier, lip biting) _____
Any injuries to the mouth, teeth, head? _____
Brushing / flossing habits? _____
Any dental problems the child has complained about? _____
Anthing about the child's teeth / mouth / smile you are concerned about? If yes, explain: _____

_____

Is the child now in orthodontic treatment? YES / NO If yes, when started? _____
Has there been orthodontic treatment? YES / NO To completion? YES / NO Date finished ____/____/___
Are there orthodontic problems you are aware of and concerned about? If yes, explain: _____

_____

Are you permanent in the area? YES / NO If not, until when will you be here? _____

Medical History

Child's physician _____ Phone Number _____
Last physical exam _____ Results: _____
Is child under physician's care now? YES / NO Explain: _____
Has child been hospitalized? YES / NO Explain: _____
Has child had surgery? YES / NO Explain: _____
Please list all drugs the child is currently taking _____
Any drug allergies? YES / NO Please list: _____

Has child any history of or problems with any of the following?

___ AIDS / HIV
___ Asthma
___ Attention Deficit Disorder
___ Attention Deficit Hyperactivity Disorder
___ Congenital Heart Disease
___ Convulsions
___ Coordination
___ Diabetes
___ Disabilities
___ Emotional Problems
___ Epilepsy
___ Fainting
___ Hearing
___ Hemophilia
___ Heart Problems
___ Heart Murmur
___ Malignancies
___ Mitral Valve Prolapse
___ Tuberculosis
___ Rheumatic Heart Defects
___ Other _____

Signature of Parent / Guardian: _____ Date: _____
Signature of Doctor / Hygienist: _____ Date: _____

Dental Group of Mentor
Patient Consent Form

I understand that I have certain rights to privacy regarding my protected health information. These are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to 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 Privay Practices,* which contains a more completed description of my protected health information, and my rights under HIPPA. I understand that you reserve the right to change the terms of this otice 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 treatent, payment and healthcare operations, but that you are not required to agree to these restrictions. However, if you do agree, you are bound to comply with these instructions.

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.

Date _____
Print Patient Name _____
Signature of Patient / Guardian _____
Relationship to Patient _____

Dental Group of Mentor
9571 Mentor Avenue, Mentor, OH 44060
(440) 352-5700

Dental Group of Mentor
Financial Policy

Dear Patient:

In an effort to reduce costs, increase efficiency and maintain the highest level of professional care, we have established a financial policy that both patients and office personnel must adhere to.

Our Office Financial Policy is as follows:

I. We accept payment by CASH, CHECK, and MOST MAJOR CREDIT CARDS.

II. As a courtesy, we will accept most insurances. and will gladly process your claim - however any estimated deductibles, co-payments, and secondary coverages will be due in full at time of visit.

_____ **Initialed by patient.**

III. Although our office will process your insurance claims, please understand it is your responsibility to satisfy any account blanace in full for all services rendered.

If you hae any questions regarding these financial policies, please do not hesistate to speak to our office personnel. We are here to help you in every way.

PLEASE ACKNOWLEDGE THAT YOU UNDERSTAND THE ABOVE POLICIES

Patient Signature: _____ Date: _____

_____

Dental Group of Mentor