



# Pediatric Dentistry of Forsyth

Dr. Jason Bongiovi

Date: \_\_\_\_\_ How did you hear about our office? \_\_\_\_\_

Patient: \_\_\_\_\_  
Last name First Name MI Preferred Name

Address: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Cell/Other Phone: \_\_\_\_\_ SSN: \_\_\_\_\_

Email: \_\_\_\_\_

How would you like to receive courtesy notifications? Please circle one Home# Cell # Email

Sex: Male Female Age: \_\_\_\_\_ Birthdate: \_\_\_\_\_

Mother/Legal Guardian's Name: \_\_\_\_\_ Occupation/Employer: \_\_\_\_\_

Father/Legal Guardian's Name: \_\_\_\_\_ Occupation/Employer: \_\_\_\_\_

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## If you have insurance and have not yet provided insurance information, please complete this section

Dental Insurance \_\_\_\_\_ Group Number: \_\_\_\_\_

Policyholder's Name: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Policyholder's Address (if not same as above): \_\_\_\_\_

Policyholder's Employer: \_\_\_\_\_ Policyholder's Work Phone: \_\_\_\_\_

Policyholder's SSN: \_\_\_\_\_ Policyholder's Birthdate: \_\_\_\_\_

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## Please read and sign below

**Assignment/Release:** I, the undersigned, assign directly to Pediatric Dentistry of Forsyth all benefits, if any otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize Pediatric Dentistry of Forsyth to release all information necessary to secure payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

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

**Minor/Child Consent:** I, being the parent or guardian of the patient listed above do hereby request and authorize the dental staff of Pediatric Dentistry of Forsyth to perform necessary dental services for my child, including but not limited to radiographs, local anesthetics, nitrous oxide analgesia, oral sedatives, and other acceptable methods to accomplish these services, whether or not I am present at the actual appointment when the treatment is rendered.

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

# Patient Medical History

Is your child currently under the care of a physician/pediatrician? \_\_\_\_ No \_\_\_\_ Yes

If yes what is the name of the doctor/practice? \_\_\_\_\_

Is your child taking any medication? : \_\_\_\_ No \_\_\_\_ Yes If yes, please list them. \_\_\_\_\_

Is your child allergic to any medicines or food?: \_\_\_\_ No \_\_\_\_ Yes \_\_\_\_\_

Is your child allergic to latex or itching or swelling with dental visits? \_\_\_\_ No \_\_\_\_ Yes \_\_\_\_\_

Has your child ever had any surgery (including ear tubes, tonsils and adenoids, etc)? \_No\_ Yes Please list surgeries \_\_\_\_\_

Has your child ever been hospitalized? \_\_\_\_ No \_\_\_\_ Yes Please list the reasons and the names of hospitals \_\_\_\_\_

## Please Check any of these conditions which your child presently has or has previously had:

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Anemia            | <input type="checkbox"/> Ear Disorders       | <input type="checkbox"/> Hyperactivity        | <input type="checkbox"/> Premature Birth         |
| <input type="checkbox"/> Asthma            | <input type="checkbox"/> Seizure Disorders   | <input type="checkbox"/> Cerebral Palsy       | <input type="checkbox"/> Rheumatic Fever         |
| <input type="checkbox"/> Bleeding Problems | <input type="checkbox"/> Eye Disorders       | <input type="checkbox"/> Kidney Disease       | <input type="checkbox"/> Stomach Problem         |
| <input type="checkbox"/> Bone Disorder     | <input type="checkbox"/> Fainting            | <input type="checkbox"/> Liver Disease        | <input type="checkbox"/> Skin Disease            |
| <input type="checkbox"/> Brain Disorder    | <input type="checkbox"/> Heart Condition     | <input type="checkbox"/> Lung Disease         | <input type="checkbox"/> Speech Problem          |
| <input type="checkbox"/> Shunt             | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Mental Retardation   | <input type="checkbox"/> Other Medical Condition |
| <input type="checkbox"/> Cancer            | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Muscle Disorder      |  |
| <input type="checkbox"/> Diabetes          | <input type="checkbox"/> Hormone Disorder    | <input type="checkbox"/> Nose/Throat Disorder |  |

## None – to the best of my knowledge, my child is healthy and has not had any of these conditions

Is this your child's first visit to the dentist? \_\_\_\_ No \_\_\_\_ Yes, Please list dates and services performed \_\_\_\_\_

What is your main concern about your child's health? \_\_\_\_\_

What is the source of your drinking water? \_\_\_\_ City/County System \_\_\_\_ Well \_\_\_\_ Bottled

Has your child ever been given fluoride tablets, drops, or rinse? \_\_\_\_ No \_\_\_\_ Yes

Has your child ever had any injuries to the mouth or face area? \_\_\_\_ No \_\_\_\_ Yes

Does your child have any of the following habits: finger/thumb sucking, pacifier? \_\_\_\_ No \_\_\_\_ Yes

How often are your child's teeth brushed? \_\_\_\_\_ By whom? \_\_\_\_\_

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

I certify that the above information is accurate and complete to the best of my knowledge. I understand that any errors or omissions could harm my child's dental treatment and/or their overall health. I will not hold Dr. Jason Bongiovi or his staff responsible for the results of any errors or omissions in the information I have provided on this form.

Legal guardian/Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_