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: ______________________

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: __________________

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:

- ❑ Anemia
- ❑ Asthma
- ❑ Bleeding Problems
- ❑ Bone Disorder
- ❑ Brain Disorder
- ❑ Shunt
- ❑ Cancer
- ❑ Diabetes
- ❑ Ear Disorders
- ❑ Seizure Disorders
- ❑ Eye Disorders
- ❑ Autism
- ❑ Heart Condition
- ❑ Heart Murmur
- ❑ High Blood Pressure
- ❑ Hormone Disorder
- ❑ Hyperactivity
- ❑ Cerebral Palsy
- ❑ Kidney Disease
- ❑ Liver Disease
- ❑ Lung Disease
- ❑ Developmental Delay
- ❑ Muscle Disorder
- ❑ Nose/Throat Disorder
- ❑ Premature Birth
- ❑ Rheumatic Fever
- ❑ Stomach Problem
- ❑ Skin Disease
- ❑ Speech Problem
- ❑ Other Medical Condition

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:

Pediatric Dentistry of Forsyth: Office Policies

Broken Appointment Policy

Dr. Bongiovi and staff pride themselves on treating our patients in a timely manner. We realize that your time is just as valuable as ours and make every effort possible to see our patients within 15 minutes of their scheduled appointment. To be able to accomplish this we ask that you respect our time as well and give us 24 hours notice if you are unable to be present for your scheduled appointment. Your scheduled appointment is reserved specifically for you and your child. Any change in this appointment affects the time that we are able to spend with you as well as the other patients to be treated that day. If a cancellation is unavoidable, please call the office at least 24 hours in advance so that we may give that time to another patient. We will make every effort to try to confirm your child's appointment. If two (2) broken/missed appointments or two (2) cancellations without 24 hours notice occur, our office reserves the right not to schedule any subsequent appointments and there will be a $40.00 broken appointment fee due at that time. Also, if you arrive 15 minutes late to your appointment, you may be asked to reschedule for the next available appointment time.

Parents in the Treatment Room

At Pediatric Dentistry of Forsyth, we strive to achieve a balance between allowing parents to be part of their child's dental experience and allowing children to be comfortable and confident enough to undergo treatment on their own. With this in mind, parents are invited back to observe all initial examination appointments and any emergency appointments. Parents are welcome back for all appointments for children under the age of 3. We strongly encourage you to allow your older children to undergo their dental experience on their own. We request the parents stay in the waiting room for restorative treatment. This allows Dr. Bongiovi and staff to give your child 100% of their attention and focus on their treatment needs. If you have ANY question regarding this policy please feel free to ask Dr. Bongiovi personally before any treatment is performed.

Financial Policy

Our office will attempt to verify your insurance coverage prior to each appointment and advise you if there are any routine services which are not covered. This is not always possible and sometimes the balance due at the time of treatment. **In the event your insurance company does not reimburse our office as expected, you will be responsible for any remaining balance.** We encourage you to contact your insurance company prior to your child's visit if you have any questions regarding this matter. We are happy to assist you in any way in understanding and maximizing your benefits.

Parent/Guardian Signature: ______________________________ Date: __________