Appointment Date: _____

Patient Information

Patient Name: _____ Preferred name: _____ ☐ Male ☐ Female
Last First

Birthdate: _____ Social Security #: _____

Phone (Home): _____ (Cell): _____

Preferred Contact Email 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 – Other**
  _____
- ☐ **ADHD/ADD**
- ☐ **Anemia**
- ☐ **Apraxia**
- ☐ **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**
- ☐ **Speech Therapy**
- ☐ **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: _____
- Has your child ever been under the care of an ENT? ☐ Yes ☐ No
  If yes, please explain: _____
- 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? _____

Parent or Guardian Information

Parent/Guardian: _____ ☐ **Married** ☐ **Single** ☐ **Other**

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address (if different from child): _____

Employer Name: _____ Occupation: _____

Parent/Guardian: _____ ☐ **Married** ☐ **Single** ☐ **Other**

Social Security #: _____ Birth Date: _____

Phone (Home): _____ (Work): _____ (Cell): _____

Address (if different from child): _____

Employer Name: _____ Occupation: _____

Primary Dental 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 Dental 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