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

6 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?

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

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

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.

January 2020

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 also understand that the office of Zambito Family Dentistry can text the cellular number provided on the paperwork with updated appointment information and account information.

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