

Mike D. Mysinger, D.D.S.
Specialist in Pediatric Dentistry
www.DrMysinger.com
Welcome to our Office!

Today's Date _____

Child's First Name _____ MI _____ Last Name _____ Goes By _____

Date of Birth _____ Age _____ Sex M _____ F _____ Weight _____

Child's Address _____ Home Phone No. _____

_____ Soc. Sec. No. _____

City _____ State _____ Zip _____ Email address _____

Please check if child is allergic to or have had problems with the following: Latex
Penicillin/Amoxicillin Codeine Erythromycin Local injected anesthetics Sulfa Other _____

Father/Step/Guardian

Mother/Step/Guardian

First Name _____ MI _____ Last Name _____

First Name _____ MI _____ Last Name _____

DOB _____ Social Sec. No. _____

DOB _____ Social Sec. No. _____

Employer _____ Work Phone _____

Employer _____ Work Phone _____

Occupation _____ Cell Phone _____

Occupation _____ Cell Phone _____

Address if different than child: _____

Address if different than child: _____

Has any member of your family been a patient of this office before? Yes No

Name (s) _____

Closest relative or friend to call in case of emergency _____

Relationship to patient _____ Phone No. _____

Whom may we "Thank" for referring you to our office? _____

Dental Insurance:

Primary Subscriber's Name: _____ Relationship to patient _____

Name of Insurance Company _____ Name of Employer _____

Soc. Sec. No. _____ Date of Birth _____

Permission to treat Child: Because your child is a minor, it becomes necessary that signed permission be obtained from the parent or guardian before any and/or all necessary dental service can be performed by Dr. Mysinger and/or staff. Authorization is hereby granted as such. Furthermore, I will be financially responsible for any bill incurred by patient for dental treatment.

_____ Relationship to Patient _____

Signature of Parent (or Guardian)

(Please see Reverse side)

Child's current physical health is: Good Fair Poor

Child's Physician _____ Phone No. _____ Date of last visit _____

Is child currently under the care of a physician? Yes No

If yes, please explain _____

Is child presently taking any medication? Yes No

If yes, please list _____

At what age was the child weaned from the bottle? _____ nursing? _____ pacifier? _____

Is this the child's first visit to the dentist? Yes No

Does the child suck his/her thumb or finger? Yes No

Does child use a pacifier? Yes No

Is the child on well water? Yes No

Please check if child has been treated for or told that they have:

- | | | |
|--|---|--|
| <input type="checkbox"/> Abnormal Bleeding | <input type="checkbox"/> Cleft Lip/Palate | <input type="checkbox"/> Kidney/Liver Disease |
| <input type="checkbox"/> AIDS/HIV + | <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Mental Disorder |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mitral Valve Prolapse |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Difficulty Breathing/Lung Problems | <input type="checkbox"/> Nervous Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Down's Syndrome | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Autism | <input type="checkbox"/> Emotional Disorder | <input type="checkbox"/> Sensory Issues |
| <input type="checkbox"/> Blood Disorders | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> Severe Headaches |
| <input type="checkbox"/> Blood Transfusion | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Brain Damage | <input type="checkbox"/> Hearing Disorders | <input type="checkbox"/> Speech Disorder |
| <input type="checkbox"/> Cancer/Tumor | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Spina Bifida |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Heart Surgery | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Chemo/Radiation therapy | <input type="checkbox"/> Hepatitis/Jaundice | Other _____ |

Financial & Insurance Agreement

Payment of fees and deductibles are due **in full** at the time of treatment, regardless of insurance coverage. If child has dental coverage, as a courtesy, necessary forms will be completed to help expedite insurance carrier payments. We reserve the right to not file problem insurance carriers. The insurer is responsible for paying any amount not paid by their insurance company within 15 days of notification. If insurance company does not pay the claim within 90 days, the bill will become the insurer's responsibility. If account falls delinquent and is turned over to a collection agency, the insurer will be responsible for late fees and the additional 40% collection fee. All family members will be dismissed from the practice.

Your appointment is made for the time that we expect to see you. If you are late or miss your appointment, your child or someone else's child is denied time for needed dental services. If late, you may be asked to wait to be worked in or asked to reschedule. A charge will be assessed for each appointment missed or canceled less than 24 hours in advance of your appointment time. After missing 2 appointments, you may be dismissed from the practice.

I have read the above statements regarding our office policies and I understand and agree to the terms.

Signed: _____ Date _____

PATIENT ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I, _____, have received a copy of this office's **NOTICE OF PRIVACY PRACTICES** as required by federal law.

Print Patient's Name Print Parent/Guardian Name Sign Parent/Guardian Name Date

For office use: On the date above we made a good faith effort to obtain written acknowledgement of receipt of our NOTICE OF PRIVACY PRACTICES. We were unable to obtain acknowledgement for the following reason: _____