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

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

First Name_____ MI___ Last Name _____

DOB _____ Social Sec. No. _____

Employer _____ Work Phone _____

Occupation _____ Cell Phone _____

Address if different than child: _____

_____

Mother/Step/Guardian

First Name _____ MI___ Last Name _____

DOB _____ Social Sec. No. _____

Employer _____ Work Phone _____

Occupation _____ Cell Phone _____

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:

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