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Pediatric Dentistry of Central Ohio

HEALTH UPDATE

Patient Information

Patient first name: _____ Last name: _____ Date of birth: _____

Patient's home address: _____

Mother's name: _____ Mobile #: _____

Mother's email address: _____

Father's name: _____ Mobile #: _____

Father's email address: _____

☐ Has your dental insurance changed?

If there has been a change in dental insurance, please provide your new insurance below.

Policy holder: _____ Policy holder's SSN: _____

Policy holder's employer: _____

Insurance company and phone number: _____

Please indicate who is financially responsible for the account: ☐ Mother ☐ Father ☐ Other _____

Responsible party SSN: _____

Responsible party address: _____

Responsible party phone #: _____

☐ Have there been any changes to your general health within the past year?

Please describe: _____

☐ Are you currently experiencing any dental pain or discomfort?

Please describe: _____

Disclaimer and signature

FINANCIAL POLICIES:
Payment for professional services is due at the time dental treatment is provided. If your insurance has copays and/or a deductible, the estimated amount will be collected at the time of service. If you do not have dental insurance, the full amount will be collected at the time of service. Past due accounts are subject to $5.00 monthly billing fees until the account is paid in full. Delinquent accounts are also subject to collection action after four failed attempts to collect the debt. In the event that your family account is submitted to our collection agency, the patient doctor relationship will be terminated. We will transfer any records upon your request.

BROKEN APPOINTMENT POLICIES: A charge of $30.00 is made for hygiene appointments that are missed, cancelled, or rescheduled when less than 24 hours' notice is given. The charge will be $50.00 for a treatment appointment.

Recare dental visits typically include an exam, cleaning, x-rays, and fluoride treatment. Your signature provides consent for these procedures.

Signature: _____ Date: _____