



WE PROVIDE GENTLE, ONE-ON-ONE CARE TO BUILD A FOUNDATION FOR LIFELONG DENTAL HEALTH.

GENERAL INFORMATION:

PATIENT .....

Child's Name \_\_\_\_\_ Age \_\_\_\_\_ Gender \_\_\_\_\_

Name child goes by \_\_\_\_\_ Primary Physician \_\_\_\_\_

Date of birth \_\_\_\_\_ Place of birth \_\_\_\_\_

Favorite pastime activity, pets, or special interest: \_\_\_\_\_

PARENTS AND FAMILY .....

Parent's Name \_\_\_\_\_

Home Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Home Phone \_\_\_\_\_ Email \_\_\_\_\_

Person responsible for account \_\_\_\_\_

Name, address & phone of parents' next-of-kin not living at same address \_\_\_\_\_

List names of other family members who are patients here \_\_\_\_\_

Family dentist \_\_\_\_\_

FATHER .....

Father's employer \_\_\_\_\_

Occupation \_\_\_\_\_ Bus. Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Business Address \_\_\_\_\_

Father's SS# \_\_\_\_\_ Father's date of birth \_\_\_\_\_

MOTHER .....

Mother's employer \_\_\_\_\_

Occupation \_\_\_\_\_ Bus. Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_

Business Address \_\_\_\_\_

Mother's SS# \_\_\_\_\_ Mother's date of birth \_\_\_\_\_

OTHER .....

Whom may we thank for referring you? \_\_\_\_\_



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**MEDICAL HISTORY** .....

- Is your child allergic to any food or drug? .....Y or N  
 If so, please list: \_\_\_\_\_
- Is your child presently taking any medication?.....Y or N  
 If so, please list: \_\_\_\_\_
- Is your child being treated by a physician? .....Y or N
- Has your child ever been hospitalized?.....Y or N  
 If so, for what and when? \_\_\_\_\_
- Has your child ever received general anesthesia?.....Y or N  
 If so, were there any complications? \_\_\_\_\_
- Has any family member had complications during general anesthesia? .....Y or N  
 If so, please explain: \_\_\_\_\_
- Does your child have a dental condition that is hereditary? .....Y or N  
 If so, please explain: \_\_\_\_\_

Has your child ever been diagnosed with any of the following conditions?

- |  |   |   |                                       |
|--|---|---|---------------------------------------|
| <b>Y N Conditions:</b>                           | <b>Y N Conditions:</b>                          | <b>Y N Conditions:</b>                      |                                       |
| <input type="checkbox"/> Abnormal Bleeding       | <input type="checkbox"/> Hearing Loss           | <input type="checkbox"/> Rheumatic Fever    |                                       |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Heart Murmur           | <input type="checkbox"/> Scarlet Fever      |                                       |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Hemophilia             | <input type="checkbox"/> Sickle Cell Anemia |                                       |
| <input type="checkbox"/> Brain Injury            | <input type="checkbox"/> Hepatitis              | <input type="checkbox"/> Spina Bifida       |                                       |
| <input type="checkbox"/> Cancer                  | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Whooping Cough     |                                       |
| <input type="checkbox"/> Cerebral Palsy          | <input type="checkbox"/> HIV/AIDS               | <input type="checkbox"/> Other _____        |                                       |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Hyperactivity          |   |                                       |
| <input type="checkbox"/> Convulsions/Seizures    | <input type="checkbox"/> Hypoglycemia           | <b>Y N Allergies:</b>                       | <b>Y N Allergies:</b>                 |
| <input type="checkbox"/> Cystic Fibrosis         | <input type="checkbox"/> Jaundice               | <input type="checkbox"/> Aspirin            | <input type="checkbox"/> Latex        |
| <input type="checkbox"/> Developmentally Delayed | <input type="checkbox"/> Leukemia               | <input type="checkbox"/> Codeine            | <input type="checkbox"/> Metals       |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Measles                | <input type="checkbox"/> Dental Anesthetics | <input type="checkbox"/> Penicillin   |
| <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Mental Retardation     | <input type="checkbox"/> Erythromycin       | <input type="checkbox"/> Tetracycline |
| <input type="checkbox"/> Eye Problems            | <input type="checkbox"/> Orthopedic Problems    | <input type="checkbox"/> Jewelry            |                                       |
| <input type="checkbox"/> Fainting Spells         | <input type="checkbox"/> Otitis (Ear Infection) |   |                                       |
| <input type="checkbox"/> Fever Blisters          | <input type="checkbox"/> Pneumonia              | Other Allergies: _____                      |                                       |
| <input type="checkbox"/> Hearing Loss            | <input type="checkbox"/> Pregnancy              | _____                                       |                                       |
| <input type="checkbox"/> Drug Abuse              | <input type="checkbox"/> Psychiatric Problems   | _____                                       |                                       |

- Does your child brush regularly? ....Y N
- Does your child use any of the following:
- Fluoridated water? .....Y N
  - Fluoride vitamins? .....Y N
  - Fluoride rinse/gel? .....Y N
  - Fluoride toothpaste? .....Y N
- Has your child been seen by a dentist before?... Y N
- Has your child experienced any unfavorable reaction to dental or medical care? ..... Y N
- Has your child had any accidents involving his/her teeth? ..... Y N
- Is there anything you would like to discuss personally with Dr. Swauger?..... Y N

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent \_\_\_\_\_

Date \_\_\_\_\_

FOR OFFICE USE ONLY  
 Medical History Alerts:

Medical History Update Summary:

DATE REVIEWER  
 \_\_\_\_\_  
 DATE REVIEWER  
 \_\_\_\_\_

Medical History Update Summary:

DATE REVIEWER  
 \_\_\_\_\_  
 DATE REVIEWER  
 \_\_\_\_\_



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**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE:**

Child's Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

Telephone \_\_\_\_\_ E-Mail \_\_\_\_\_

I, \_\_\_\_\_, have received a copy of this office's  
Notice of Privacy Practices.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

If you are signing this authorization on behalf of a minor, please note your relationship to the child in the space provided above .

\*\*\*\*\*  
*Include this document of receipt in the individual's records.*



WE PROVIDE GENTLE, ONE-ON-ONE CARE TO BUILD A FOUNDATION FOR LIFELONG DENTAL HEALTH.

**ATTENTION:**

We make every effort to notify our patients of appointments they have made. If you are unable to keep the appointment that you were given, you must kindly give 24 hours notice. Otherwise, there will be a \$25 charge to your account.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date



## **PAYMENT & INSURANCE POLICY - Please Read and Sign**

If you have dental insurance, we are happy to file your insurance claims at our expense. **Your portion or co-pay is due, in full, on the day of service or the day treatment is received.** We will be happy to inform you or your portion due if you request it before the date of the appointment or treatment. **If you do not have dental insurance, payment in full is due on the day treatment is received.**

If our fees are over the usual and customary amount your insurance company sets and will pay, you are responsible for the amount the insurance company does not pay. Every insurance company is different and sets their own limits on what they will pay.

We need your help in keeping insurance and billing information current and accurate. **We can only file insurance claims with the information that you provide to our office, and it is essential that it be correct for claim payment.** If we find it necessary to re-file your claim due to incorrect insurance information, there will be a charge for re-filing the claim(s). We deal with hundreds of insurance plans, and it is impossible for us to know what your insurance policy covers. All insurance policies are different. We will give you an estimate of the expected benefits, but payment for all services provided are ultimately your responsibility. Your insurance company will determine the final benefits and your portion of the total bill. If there are any questions regarding payment of a claim, please contact your insurance company. If your insurance company has not responded to our claims within 90 days after filing, the entire balance will become your responsibility. **The balance is your responsibility whether your insurance company pays or not. We will bill the patient 3 times, and after the third and final bill, the balance will be turned over to our collection attorney.** If the account is turned over for collections, the guarantor agrees to pay reasonable attorney fees and the cost of collections.

When you arrive at our office, verify any changes in your address, telephone number, change of employment, and/or insurance information. It is your responsibility to know what your benefits are and what deductible you are expected to meet in the calendar year. Employers provide a schedule of benefits, or you may call your insurance company directly.

**Your estimated portion of the total charge is expected the day the service is provided.** If you have dental insurance, expect an explanation of benefits to arrive at your mailing address within 3-4 weeks. Please remember, the estimate you are given at the time of treatment is only an estimate. Payment by your insurance company can vary for many reasons. If you receive a notice stating your insurance company will make no payment, please contact them for an explanation. Dental insurance is a contract between you and your insurance company.

**Divorced parents and step-families must resolve their own financial arrangements. The divorce decree is a family arrangement, and it is not our responsibility.**

By signing below, I authorize the staff of Kurt R. Swauger, D.D.S. to perform the necessary services my child/children may need, with the prior permission of a parent or guardian. My signature shows I have read and full understand the Payment & Insurance Policy.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date