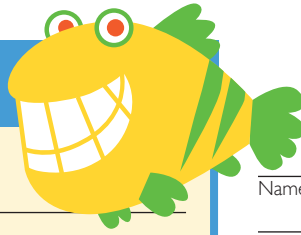


# YOUR CHILD



Patient ID# \_\_\_\_\_

## RESPONSIBLE PARTY

Child's name \_\_\_\_\_

Nickname \_\_\_\_\_

Sex \_\_\_\_\_

Birthdate \_\_\_\_\_

Age \_\_\_\_\_

SS# / SIN \_\_\_\_\_

School \_\_\_\_\_

Grade \_\_\_\_\_

Child's home address \_\_\_\_\_  
\_\_\_\_\_

City \_\_\_\_\_

State/Province \_\_\_\_\_

ZIP \_\_\_\_\_

Phone \_\_\_\_\_

Name \_\_\_\_\_

Relationship \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

SS# / SIN \_\_\_\_\_

DL# \_\_\_\_\_

Email \_\_\_\_\_

## WHO IS RESPONSIBLE FOR MAKING APPOINTMENTS?

Name \_\_\_\_\_

Home phone \_\_\_\_\_

Work phone \_\_\_\_\_

Cell phone \_\_\_\_\_

Best time to call \_\_\_\_\_

AM

PM

**MOTHER**

Stepmother

Guardian

**FATHER**

Stepmother

Guardian

### PARENT IS:

Name \_\_\_\_\_

Home phone \_\_\_\_\_

Work phone \_\_\_\_\_

Cell phone \_\_\_\_\_

SS# / SIN \_\_\_\_\_

Employer \_\_\_\_\_

Birthdate \_\_\_\_\_

Occupation \_\_\_\_\_

Name \_\_\_\_\_

Home phone \_\_\_\_\_

Work phone \_\_\_\_\_

Cell phone \_\_\_\_\_

SS# / SIN \_\_\_\_\_

Employer \_\_\_\_\_

Birthdate \_\_\_\_\_

Occupation \_\_\_\_\_

Single

Married

Separated

Divorced

Widowed

## WELCOME TO NAPLES PEDIATRIC DENTISTRY!

We strive to make each of your child's visits pleasant and comfortable. Our goal is to teach your children oral habits which will help keep their smiles beautiful for a lifetime.

How did you hear about us? \_\_\_\_\_



## PRIMARY DENTAL INSURANCE

Insured's name \_\_\_\_\_

Relationship \_\_\_\_\_

Birthdate \_\_\_\_\_

SS# / SIN \_\_\_\_\_

Employer \_\_\_\_\_

Date employed \_\_\_\_\_

Occupation \_\_\_\_\_

Insurance company \_\_\_\_\_

Group # \_\_\_\_\_

Employee # \_\_\_\_\_

Insurance company address \_\_\_\_\_  
\_\_\_\_\_

Happy kids.  
Sparkly smiles.



Dr. Sandor.

Naples Pediatric Dentistry  
www.drmarilynsandor.com 592-0800

## MEDICAL HISTORY

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Your child's overall health, as well as any medications which your child takes, could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Name of your child's primary care physician and/or specialists?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has your child ever been hospitalized or had a major operation?

Yes  No

Has your child ever had a serious head or neck injury?

Yes  No

Is your child taking any medications, pills, or drugs?

Yes  No

If yes, please list: \_\_\_\_\_

Is your child on a special diet?

Yes  No

If yes, please describe: \_\_\_\_\_

Does your child use tobacco?

Yes  No

Is your child allergic to any of the following?

Yes  No

- |                                       |                                     |                                      |
|---------------------------------------|-------------------------------------|--------------------------------------|
| <input type="checkbox"/> Aspirin      | <input type="checkbox"/> Penicillin | <input type="checkbox"/> Amoxicillin |
| <input type="checkbox"/> Codeine      | <input type="checkbox"/> Latex      | <input type="checkbox"/> Tree-nuts   |
| <input type="checkbox"/> Other: _____ |                                     |                                      |

Does your child have or has your child had any of the following?

- |   |   |  |   |
|---|---|--|---|
| <input type="checkbox"/> ADD/ADHD         | <input type="checkbox"/> Cold/Fever sore    | <input type="checkbox"/> Heart murmur            | <input type="checkbox"/> Respiratory problems     |
| <input type="checkbox"/> AIDS/HIV         | <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Heart conditions        | <input type="checkbox"/> Recurrent ear infections |
| <input type="checkbox"/> Anaphylaxis      | <input type="checkbox"/> Digestive disorder | <input type="checkbox"/> High blood pressure     | <input type="checkbox"/> Rheumatic Fever          |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Disabilities       | <input type="checkbox"/> Immunologic             | <input type="checkbox"/> Thyroid diseases         |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Eating disorder    | <input type="checkbox"/> Kidney disease          | <input type="checkbox"/> Tonsillitis              |
| <input type="checkbox"/> Bronchiolitis    | <input type="checkbox"/> Epilepsy/seizures  | <input type="checkbox"/> Leukemia                | <input type="checkbox"/> Tuberculosis             |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Headaches          | <input type="checkbox"/> Liver disease/Hepatitis | <input type="checkbox"/> Vesicoureteral reflux    |
| <input type="checkbox"/> Cleft lip/palate | <input type="checkbox"/> Hearing problems   | <input type="checkbox"/> Neurological problems   | <input type="checkbox"/> Vision problems          |

If your child had any serious illness not listed above, please describe here:

\_\_\_\_\_  
\_\_\_\_\_

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Happy kids.  
Sparkly smiles.



Dr. Sandor.

Naples Pediatric Dentistry  
www.drmarilynsandor.com 592-0800

## DENTAL HISTORY

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Age until bottle-fed? \_\_\_\_\_

Age until breast-fed? \_\_\_\_\_

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

Is your child experiencing dental pain right now? Yes  No

Has your child had dental pain/toothaches in the past? Yes  No

Does your child grind his/her teeth? Yes  No

Does your child bite or suck his/her cheek, lips, or thumb? Yes  No

Do you think there is anything wrong with your child's teeth right now? Yes  No

Is your child nervous about this appointment? Yes  No

Do your child's gums bleed when they are brushed or flossed? Yes  No

Do you assist your child with brushing and flossing? Yes  No

Does your child use fluoride products: Rinse, drops, tablets? (Please circle) Yes  No

Is your child's water fluoridated? Yes  No

Does your child eat well-balanced meals? Yes  No

How often does your child brush? \_\_\_\_\_

How often does your child floss? \_\_\_\_\_

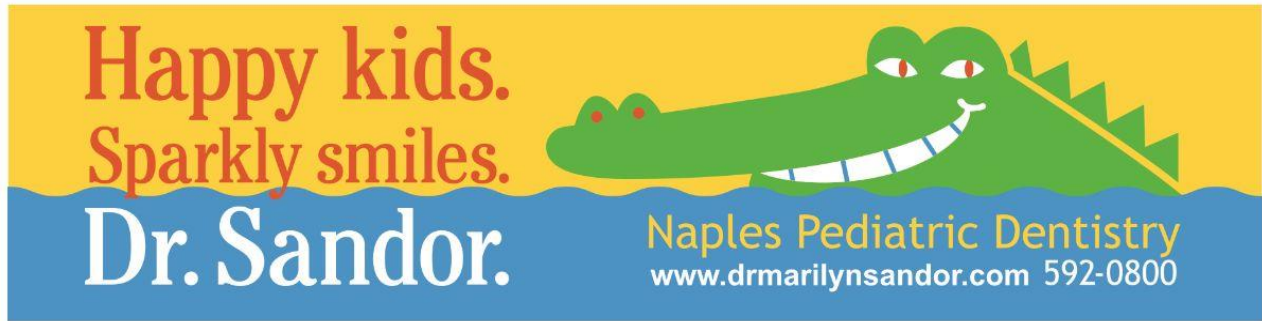
## AUTHORIZATION AND RELEASE

I authorize Dr. Sandor to examine the above-named patient and perform the dental procedures explained to me, including the taking of any necessary dental radiographs to evaluate the oral health of my child. To the best of my knowledge, the questions of this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

I authorize Dr. Sandor to release the records of any treatment or examination rendered to my child during the period of such dental care to other health practitioners as required for the purposes of caring for my child's health. I understand that this office may not accept assignment of benefits. I understand that I am directly responsible for the payment of all services rendered on behalf of my child. My insurance company may reimburse me directly according to the terms of my policy. I understand that if it is necessary for Naples Pediatric Dentistry to seek legal consultation for collection actions, I am financially responsible for the unpaid debt and any necessary attorney and court fees required to collect that debt.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_



**CONSENT FOR RELEASE OF MEDICAL RECORDS AND DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_ (parent or guardian), hereby authorize Naples Pediatric Dentistry (Marilyn C. Sandor, D.D.S., M.S., P.A.) to disclose medical information contained in my child’s pediatric dental record in accordance with the Notice of Privacy Practices. I have been given the opportunity to review the Notice of Privacy Practices, to ask questions about it, and do hereby agree to its terms. A copy of this signed, dated consent shall be as effective as the original. I release, hold harmless, and agree to indemnify Naples Pediatric Dentistry (Marilyn C. Sandor, D.D.S., M.S., P.A.), and its employees and agents for any and all liability. This includes, but is not limited to, negligence arising from or occurring as a result of this consent. I specifically authorize Naples Pediatric Dentistry (Marilyn C. Sandor, D.D.S., M.S., P.A.) to disclose verbally, by mail, fax, or unencrypted e-mail the contents of my child’s medical records.

Complete as Applicable:

- Please send a copy of my child’s records (including information from other health-care providers that it may contain) to \_\_\_\_\_ at \_\_\_\_\_ . I understand that my child’s records may be subject to re-disclosure by recipient(s) and unprotected by federal and state law.
- Please allow \_\_\_\_\_ to pick up a copy of my child’s records (including information from other healthcare providers that it may contain).
- I acknowledge there will be a charge for duplication of records as allowed for by Florida law.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_



**AUTHORIZATION FOR MINOR CHILD ACCOMPANY**

Patient's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

I, \_\_\_\_\_ give \_\_\_\_\_  
(Parent or Legal Guardian's Name) (Authorized Person's Full Name)

my permission to accompany my child to Naples Pediatric Dentistry for his/her appointment and to consent and make necessary dental and health care for my child including, but not limited to:

- Sign informed consents for preventative appointments
- Discuss post-operative instructions
- Discuss finances, treatment charges, insurance estimations, account balances and next visit charges
- Discuss dental findings, future dental treatment needs and any pertinent personal health information

As the parent or legal guardian, I understand that I must sign any treatment plans and or informed consents before any restorative procedures or invasive dental treatment can be performed for my child. I further understand that it is my responsibility to provide payment or a source of payment on the day that services are rendered, even when this authorized person brings my child.

I understand that, despite this Authorization, Naples Pediatric Dentistry, its employees and staff, in its/their sole discretion, may decide not to treat minor child, and instead require my presence during my minor child's treatment or care.

Signature of Parent/Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_



**FINANCIAL POLICY**

Payment for your child’s dental treatment is due at the time the services are performed. The parent or guardian who accompanies the patient to an appointment is responsible at that time for all costs associated with services rendered, unless prior written arrangements have been made with our office.

For your convenience, we accept cash, checks, and all major credit cards. We also participate in a financial payment program called Care Credit. Please call or ask at the reception desk for details.

Insurance benefits are determined by your employer and not your dentist. Any deductible or estimated co-payment amount will be due at the time of treatment. Insurance is not a guarantee of payment; insurance companies may not pay for all your costs. Your insurance policy is a contract between you and your insurer. As a courtesy we will be glad to file your claim for you provided you have submitted complete and accurate insurance information.

Unpaid accounts will become eligible for submission to our collection agency after ninety (90) days. If your account must be turned over to our agency to our collection agency, there will be a thirty percent (30%) collection fee added to the balance of the account.

Service charges for returned checks will apply. Please refer to the 2020 Florida Statutes for the fees applicable by Florida State Law Statute chapter 68.065 section 832.062 and 832.085.

For patients scheduled for IV anesthesia, a \$200 deposit is required. This deposit will be credited toward the dental treatment fee.

I have read and understand this financial policy.

Print Name: \_\_\_\_\_ Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_ Date: \_\_\_\_\_