# WELCOME

We appreciate your trust and confidence in choosing Plaza Dental Center. We strive to make each of your visits pleasant & comfortable.

PLAZA DENTAL CENTER
4646 Lindell Boulevard
St. Louis, MO 63108
(314) 361-1818

## 1 ABOUT YOUR CHILD

**Today's Date:**_____

**Child's Name**

Last_____

First_____(MI)___

Nickname:_____

❑ Male ❑ Female

Birthdate:___/___/___ Age____SS#:_____

School:_____Grade:_____

Child's Home Address:_____

_____

City State Zip

WHO IS ACCOMPANYING THE CHILD TODAY?

Name:_____Relation_____

Do you have legal custody of this child? ❑ Yes ❑ No

Marital Status: ❑ Single ❑ Married ❑ Divorced ❑ Widowed ❑ Separated

Previous/Present Dentist:_____

Last Visit Date____/____/____

**MOTHER'S INFORMATION:** ❑ Step Mother ❑ Guardian

Name:_____Birthdate:____/____/____

Home Phone:(___)_____SS#:_____

DL#:_____

Employer:_____

Work Phone:(___)_____Ext:_____

**FATHER'S INFORMATION:** ❑ Step Father ❑ Guardian

Name:_____Birthdate:____/____/____

Home Phone:(___)_____SS#:_____

DL#:_____

Employer:_____

Work Phone:(___)_____Ext:_____

## 2 DENTAL INSURANCE

**Person Responsible for Account:**

Name:_____

Relation:_____

Billing Address:_____

_____

Employer:_____

**Person responsible for making appointments?**

Name:_____

Work Phone:(___)_____Ext:_____ Home Phone:(___)_____

Home Phone:(___)_____SS#:_____DL#:_____

**Primary Dental Insurance**

Insurance Co. Name:_____

Insurance Co. Address:_____

_____Insurance Co. Phone:(___)_____

Group # (Plan, Local or Policy#):_____

Policy Owner's Name:_____Relation:_____

Birthdate:___/___/___ SS#:_____

Policy Owner's Employer:_____

Orthodontic Coverage? ❑ Yes ❑ No

**Secondary Dental Insurance**

Insurance Co. Name:_____

Insurance Co. Address:_____

_____Insurance Co. Phone:(___)_____

Group # (Plan, Local or Policy#):_____

Policy Owner's Name:_____Relation:_____

Birthdate:___/___/___ SS#:_____

Policy Owner's Employer:_____

Orthodontic Coverage? ❑ Yes ❑ No

## TELEPHONE

Home Phone:(___)_____ Work Phone:(___)_____ Pager or car phone:(___)_____

When is the best time to reach you? _____Where? _____ Specific days? _____

**In the event of an emergency, is there someone who lives near you that we could contact?**

His / Her Name: _____ Relation: _____

Work Phone:(___)_____Ext:_____ Home Phone:(___)_____

## 3 MEDICAL & DENTAL HISTORY

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

Why did you bring the child to the dentist today?

_____

_____

_____

_____

Has the child ever had a serious / difficult problem associated with previous dental work? ❑ Yes ❑ No Is the child's water fluoridated? ❑ Yes ❑ No

Is the child taking fluoridated supplements? ❑ Yes ❑ No

Has the child ever had any pain / tenderness in his / her jaw joint (TMJ / TMD)? ❑ Yes ❑ No

Does the child brush his / her teeth daily? ❑ Yes ❑ No

Does the child floss his / her teeth daily? ❑ Yes ❑ No

Child's Physician:_____

Phone:(___)_____ Date of last visit:____ / ____ / ____

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

Please describe the child's current physical health:

❑ Good ❑ Fair ❑ Poor

Please list all medications that the child is currently taking:_____

_____

_____

Please list all medications that the child is allergic to:_____

_____

_____

### Is the child allergic to any of the following:

| | | |
|---|---|---|
| Y N Aspirin | Y N Codeine | Y N Penicillin |
| Y N Erythromycin | Y N Latex | Y N Dental Anethetics |
| Y N Tetracycline | Y N Other | |

### Has the child ever had any of the following?

| | |
|---|---|
| Y N Abnormal Bleeding | Y N Any Hospital Stays |
| Y N Asthma | Y N Congenital Heart Defect |
| Y N Artificial Bones / Joints | Y N Artificial Valves |
| Y N Hemophilia | Y N Cancer |
| Y N Handicaps / Disabilities | Y N Hearing Impairment |
| Y N HIV+ / AIDS | Y N Tuberculosis (TB) |
| Y N Diabetes | Y N Kidney / Liver Problems |
| Y N Convulsions / Epilepsy | Y N Rheumatic / Scarlet Fever |
| Y N Heart Murmur | Y N Hepatitis |

Please discuss any serious medical problems that the child has had:_____

_____

_____

### Does the child have any of the following habits?

| | |
|---|---|
| Y N Lip Sucking / Biting | Y N Nursing Bottle Habits |
| Y N Nail Biting | Y N Thumb / Finger Sucking |

## 4 AUTHORIZATION INFORMATION

The Parent or Guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in 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 or Guardian Date

I Authorize release of any information necessary to process my dental records.

_____ _____

Signature of Patient or Parent of Minor Date

I Hereby Authorize payment directly to the dentist of the group insurance benefits otherwise payable to me.

_____ _____

Signed Insured Person Date

## 5 FOR YOUR INFORMATION

**Please read office policy:**

**Fees will be charged as services are rendered. Payment in full is expected at the time of services, or your estimated insurance co-payment when benefits are assigned to our office.**

**PATIENTS WITH INSURANCE: We will work with you to get your deserved benefits but you are responsible for payment to this office. For your convenience we estimate to you what we anticipate your insurance to pay. However, it is an estimation and should not be considered by you as your final co-payment / portion. If for any reason your insurance does not pay; what we estimate them to pay, what you estimate them to pay, pay what they pre-determine, or if they cause payment delays more than ninety days after services rendered then the balance is due by you to our office. Our office is not liable for policy limitations, exclusions, or clauses your insurance may impose to restrict / limit payment. The relationship is between you and our office and you and your insurance carrier Not between Plaza Dental Center and the insurance carrier. We expect you to pay for any services not covered by your insurance.**

**Fixed or Removable Prosthetic, such as dentures, crowns, bridges or partial dentures, are understood to be a product that is uniquely suited to each particular patient. The full fees for such service is, therefore considered to be due and payable when the initial impression is made. Prosthetics must be seated in a timely manner to insure your comfort and proper fit. If you fail to have your prosthetic permanently seated within 30 days from the date of impression, a second impression may need to be taken, and you will be charged an additional amount.**

**All x-rays taken are a part of our permanent records, there is a duplication charge for any x-rays removed from this office.**

**A service fee is charged for all returned checks.**

**If for any reason you fail to pay your balance once billed, we reserve the right to secure a collection agency to collect the debt for us. You will be liable for court cost, attorney fees, and collection agency fees necessary to enforce collection of this debt.**

**I have read and understand the above policies, and agree to the terms.**

**Patient signature**

_____ **Date:** _____