Welcome To Mark W. Garon, DDS

PEDIATRIC DENTISTRY

www.garonDDS.com

1 ABOUT CHILD

Date ____________________

Patient Name ___________________________________

Child Called _________________ Male ___ Female ___

Date of Birth _______________ Age ______

Child's Physician______________________________

Family Dentist ___________________________________

Referred By _____________________________________

Names of other children seen in this office ___________

____

2 INSURANCE INFO

PRIMARY DENTAL INSURANCE

Co.Name___________________________________

Address:___________________________________

____
CITY STATE ZIP

Phone #:___________________________________

Insured's SS#:_______________________________

Group# (Plan,Local,or Policy #)_________________

Insured's Name:_____________________________

Relation:____________Date of Birth:___/___/___

Insured's Employer:__________________________

SECONDARY DENTAL INSURANCE

Co.Name___________________________________

Address:___________________________________

____
CITY STATE ZIP

Phone #:___________________________________

Insured's SS#:_______________________________

Group# (Plan,Local,or Policy #)_________________

Insured's Name:_____________________________

Relation:____________Date of Birth:___/___/___

Insured's Employer:__________________________

____

3 ACCOUNT INFO

Mother's Name______________________________

DOB __________ Social Security # ___________

Cell Phone _________________________________

Email ______________________________________

Employer____________________________________

Occupation__________________________________

Father's Name _______________________________

DOB __________ Social Security # ___________

Cell Phone _________________________________

Email ______________________________________

Employer____________________________________

Occupation__________________________________

Billing Address ______________________________

____

Physical Address_____________________________

____

Home Phone__________________________________

4 IN THE EVENT OF EMERGENCY

Who should we contact ___________________________

Relation ______________________________________

Home Phone _______________ Cell Phone ___________

PLEASE CONTINUE ON BACK

5 DENTAL INFORMATION

Is this visit the child's first trip to a dentist? ❑ Yes ❑ No

Any unfavorable reaction to medical/dental appointments? ❑ Yes ❑ No

Any dental/mouth habits? ❑ Yes ❑ No

Is child taking a fluoride supplement?

Drops _________ Vitamins _________ Rinse _________ Other _________

Any previous injuries to mouth/teeth? __________________ Date ______________

Child's previous dentist _______________________________ Date _______________

At what age was child taken off bottle? ______________________

List any specific dental problems____

____

6 MEDICAL HISTORY

If your child in good health? _________________________________

Has your child had any history of:

Y N Rheumatic Fever

Y N Heart Trouble

Y N Mitral Valve Prolapse

Y N Asthma

Y N Diabetes

Y N Kidney Problems

Y N Liver Problems

Y N Epilepsy

Y N Brain Damage

Y N Circulation

Y N Blood Disorders

Is your child allergic to any foods, drugs, or latex? If so, please list ______________________________

Is there any history of excessive bleeding in child __________ or family member________________?

Is your child under medical care at the present time?

Reason ____________________________ Physician ____________________________

Has your child had any condition which might affect dental treatment?________________________

Is there any reason, to your knowledge, why a local anesthetic cannot be used? _______________

Is your child taking any medicine now? ____

Medication ________________________ Reason ___________________________

Does your child have a special physical ________________ or mental handicap?________________

Is special treatment required? _____________

- ***We invite you to discuss with us any questions regarding our services.The best Dental health services are based on a friendly, mutual understanding between provider and patient.***
- ***Our policy requires payment in full for all services rendered at the time of visit,unless other arrangements have been made with the Office Manager. If account is not paid within 90 days of the date of service you will be reponsible for legal fees,collection agency fees,interest charges and any other expenses incurred in collecting your account.***
- ***I authorize the staff to perform any necessary services needed during diagnosis and treatment.I also authorize the provider to release any information required to process insurance claims.***
- ***I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it's my responsibility to inform this office of any changes to the information I have provided.***
- ***I have received a copy of the patient credit policy.__________ (Initials)***

Signature:_________________________ Date_____/_____/_____