Legends DENTAL
GEORGE JEDLICKA, DMD

Child Information and Health History

Patient Name _____ Date of Birth _____
(Last) (MI) (First)

Nickname _____

Fathers Name / Legal Guardian _____ Date of Birth _____

Drivers License # _____ Social Security # _____

Mailing Address _____ City _____ State _____ Zip _____

Residence Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Mothers Name/ Legal Guardian _____ Date of Birth _____

Drivers License # _____ Social Security # _____ Cell Phone _____

Mailing Address _____ City _____ State _____ Zip _____

Residence Phone _____ Cell Phone _____

Employer _____ Work Phone _____

Emergency Contact Person _____ Phone _____
(Relationship)

Primary Dental Insurance

Insured Person _____ Date of Birth _____

Insurance Company _____ Group # _____ ID# _____

Secondary Dental Insurance

Insured Person _____ Date of Birth _____

Insurance Company _____ Group # _____ ID# _____

Consent for Dental Treatment

Payment is due in full at the time of treatment
Unless prior arrangements have been approved.

If this office accepts insurance, I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance does not cover. I also understand that if I do not present both primary and secondary insurances at the time services are rendered, I will be responsible for billing the secondary insurance. I hereby authorize payment directly to the dentist of insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment, including but not limited to collection agency fees of 35%, incurred by me. I hereby authorize release of any information, including the diagnosis and records of treatment or examination rendered, to my insurance company.

I certify that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my medical status. I authorize the dentist/dental staff to perform diagnostic procedures and treatment as may be necessary for proper dental care.

Signature _____ Date _____

Patient's Name _____ Date of Birth _____

	Yes	No	
1. Is your child allergic to anything? (medicine, food)	☐	☐	_____
2. Is your child taking any medicines at this time?	☐	☐	_____
3. Has your child ever been diagnosed and/or treated for his/her Heart?	☐	☐	_____
4. Has your child ever had Rheumatic Fever?	☐	☐	_____
5. Is your child being teated by a physician at this time?	☐	☐	When _____
6. Has your child ever been a patient in a hospital?	☐	☐	When _____
7. Has your child ever received general anesthesia?	☐	☐	_____
8. When was your child's last dental visit?			_____
9. Does your child suck fingers or thumbs?	☐	☐	_____
10. Are your child's teeth brushed once daily?	☐	☐	_____
11. What type of toothpaste does your child use?			_____
12. At what age did your child stop bottle /breast feeding?			_____

Organs and Systems

Has this child ever been treated for any of the following? Please check yes or no:

Yes	No	
☐	☐	Blood Circulatory
☐	☐	Bones
☐	☐	Endocrine Glands
☐	☐	Eyes, Ears, Nose, Throat
☐	☐	Speech / Hearing
☐	☐	Gastrointestinal (Stomach)
☐	☐	Kidney—Bladder
☐	☐	Liver
☐	☐	Muscles
☐	☐	Nervous Systems
☐	☐	Skin
☐	☐	Tonsils / Adenoids

Illness

Has this child ever been diagnose as having any of the following conditions? Please check yes or no:

Yes	No	
☐	☐	AIDS / HIV Positive
☐	☐	Anemia
☐	☐	Allergy
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Autism
☐	☐	Brain Injury
☐	☐	Cancer
☐	☐	Cerebral Palsy
☐	☐	Chicken Pox
☐	☐	Cleft Lip / Palate
☐	☐	Convulsions / Seizures
☐	☐	Diabetes
☐	☐	Diptheria
☐	☐	Emotional Disturbance
☐	☐	Epilepsy
☐	☐	Eye Problems
☐	☐	Excessive Bleeding Problem
☐	☐	Fainting
☐	☐	Hearing Loss
☐	☐	Heart Disease
☐	☐	Hemophilia
☐	☐	Hepatitis—Type _____
☐	☐	Jaundice
☐	☐	Leukemia
☐	☐	Measles
☐	☐	Mental Retardation
☐	☐	Mumps
☐	☐	Nutritional Deficiency
☐	☐	Orthopedic Problems
☐	☐	Pneumonia
☐	☐	Polio
☐	☐	Scarlet Fever
☐	☐	Scoliosis
☐	☐	Sickle Cell Anemia
☐	☐	Spina Bifida
☐	☐	Syndrome
☐	☐	Tetanus
☐	☐	Whooping Cough
☐	☐	Other _____

Reason for bringing child to the Dentist _____

Is there anything else that you think we should know about your child? _____

Signature _____ Relationship to Patient? _____ Date _____

Reviewer _____ Date _____ Comments _____

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JEROME JEDLICKA, DMD

APPOINTMENT POLICY

We see patients on an appointment basis. Your appointment time is reserved exclusively for you. We respect your time and will make every effort to remain on schedule; therefore we ask that you please arrive on time for your appointment.

We understand that circumstances arise that prevents patients from keeping appointments. If you are not able to keep an appointment, please give us a call 24 hours in advance. (exception may be made in an emergency). With this notice we can reschedule your appointment for the near future.

We request this courtesy as it allows us to see our patients promptly.

Our policy states that once the 2nd scheduled appointment is missed, a notice will be sent alerting of the consequence of missing the 3rd scheduled appointment within a 12 month period. That consequence is that the patient will be allowed emergency care only. This is defined as a probationary period and will be in effect for 12 months.

Appointment failure is defined as:

1. Any appointment for which the patient does not arrive and notify the clinic at least 24 hours in advance
2. A patient that arrives 15 minutes into the appointment

I have read and understand the above appointment policy for Legends Dental.

_____

4/2007