

**9156 Wiles Road
Coral Springs, FL 33067
(954) 255-2787**

Welcome

Health History Form

Today's Date: _____

NOTE: The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name _____
Last First MI

Goes by: _____ Male Female

Siblings that we treat _____

Child's Birthdate ____/____/____ Child's Age _____

School _____ Grade _____

Child's Home # (_____) _____

SS# _____

Child's Home Address: _____

City _____ State _____ Zip _____

Email Address: _____

2. Who may we thank for referring you to our office?

3. Mother's Information

Name _____

Mother Stepmother Guardian Birthdate ____/____/____

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

4. Father's Information

Name _____

Father Stepmother Guardian Birthdate ____/____/____

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

5. Who is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? Yes No

6. Person Responsible for Account

Name _____

Relationship _____

Billing Address _____

City _____ State _____ Zip _____

Home # (_____) _____

Work # (_____) _____

Cellular # (_____) _____

E-mail _____

7. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (_____) _____

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

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____/____/____

Social Security # _____

Policy Owner's Employer _____

8. Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (_____) _____

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

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____/____/____

Social Security # _____

Policy Owner's Employer _____

9. Dental History

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Previous Dentist's Name _____

Were any x-rays taken at previous dental visits? _____

Have there been any injuries to the teeth, face or mouth? _____

If yes, please explain _____

Why did you bring the child to the dentist today? _____

Does the child have any of the following habits?

Y N Lip Sucking / Biting Y N Nail Biting

Y N Nursing / Bottle Habits Y N Thumb / Finger Sucking

Has the child ever had a serious or difficult problem associated

with previous dental work? Yes No

If yes, please explain _____

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in his/her jaw/

joint? (TMJ/TMD)? Yes No

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

Floss his / her teeth daily? Yes No

10. Health History

Has the child ever had any of the following conditions?

Y N Abnormal Bleeding Y N Disabilities/Special Needs

Y N Allergies to any Drugs Y N Hearing Impairment

Y N Any Hospital Stays Y N Heart Disease/Murmur

Y N Any Operations Y N Hemophilia/Blood Disorders

Y N Asthma Y N Hepatitis

Y N Cancer Y N HIV + / AIDS

Y N Congenital Birth Defects Y N Kidney/Liver Conditions

Y N Convulsions/Epilepsy Y N Rheumatic/Scarlet Fever

Y N Pregnancy Y N Allergies to Latex Product

Y N Tuberculosis Y N Diabetes

Y N ADD/ADHD Y N Autism

Please discuss any serious medical conditions the child has had

Please list all drugs the child is currently taking _____

Please list all allergies _____

Child's Physician _____

Phone (_____) _____

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

Please describe the child's current physical health...

Good Fair Poor

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

11. 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 or Guardian

Date

Relationship to Patient

For Office Use Only

I verbally reviewed the medical / dental information above with the parent / guardian and patient named herein.

Initials _____ Date _____

Doctor's Comments _____

OFFICE FINANCIAL POLICY

John S. Bazos, D.M.D., P.A.

Our office, as a courtesy, is pleased to bill your insurance company as soon as your coverage is verified by our office. We will submit your claims once and assist you in every way we can. If your benefits have not been verified at the time of your appointment, you will be responsible for payment at the time of the visit.

It must be fully understood that the contract is between you and your insurance company and you are fully responsible for any amount not paid by your insurance company.

1. We will submit your insurance claim(s) once. Any change in your insurance policy and/or coverage requiring a resubmission of any claim will necessitate a \$5.00 per claim fee, payable prior to said resubmission(s).
2. If your deductible has not been met at the time of your verification, you are responsible for that amount at the time of the visit.
3. You are responsible for the percentages not paid by your insurance company on each office visit. Balances over 60 days will incur a 1.5% per month late charge.
4. Our office does NOT guarantee that your insurance will pay. We will make every attempt, at the beginning of dental care, to receive verification of your policy and what it covers. However, if for some reason, the insurance claim is denied, you are responsible for the full amount of the bill.
5. Our office will NOT enter into a dispute with your insurance company over any claim. This is your responsibility and obligation.
6. Returned checks will be assessed a \$25.00 processing fee.
7. I authorize John S. Bazos, D.M.D., P.A. to release any information to my insurance carrier that they request.
8. I authorize assignment of benefits on my behalf to John S. Bazos, D.M.D., P.A. I understand that assignment is not accepted as payment in full, I will be responsible for the balance.
9. The party that brings the child to the office will be responsible for any payment due to the provider of the services (Dr. John S. Bazos).
10. The debtor assumes all costs of collection, including but not limited to court costs, interest, collection fees, and reasonable attorney fees. Balances over 60 days will incur a 1.5% per month late charge.
11. If you have any questions about the above information, or any uncertainty regarding your insurance coverage, please ask us. We are here to help you.

Date

Signature (Parent or Authorized Person)