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

Pediatric and Adolescent Dentistry
Diplomate of the American Board of Pediatric Dentistry

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 Stepfather 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 $10.00 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. Any account that is 90 days past due will require a credit card on file for future appointments.**

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 agrees to reimburse us the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs and expenses, including reasonable attorney's fees, we incur in such collection efforts.**

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)**