Olentangy Pediatric Dentistry
45 Clairedan Drive Powell, OH 43065
(614) 433-7474 / Fax :(614) 433-9090

Today's Date: ____________ **Patient ID#:** ____________

Your Child:

Name: ______________________ Birthdate: ____________ Female: ___ Male: ___

Address: ______________________ City: ____________ State: ________ Zip: ______

Home #: ( ) ______________ Nickname: ______________________

Who may we thank for referring you? ______________________

Parent or Guardian: ____**Mother** ____**Stepmother** ____**Grandmother** ____**Guardian**

Name: ______________________ Birthdate: ____________ Marital Status:________

Address:____

City:______________________ State:__________ Zip Code:______________

Home #:______________ Cell#:______________ Work#:______________

SS#:______________ Occupation:______________________

Employer:______________ Address:______________________

Parent or Guardian: ____ **Father** ____**Stepfather** ____**Grandfather** ____**Guardian**

Name: ______________________ Birthdate:____________ Marital Status:________

Address:____

City:______________________ State:__________ Zip Code:______________

Home #:______________ Cell#:______________ Work#:______________

SS#:______________ Occupation:______________________

Employer:______________ Address:______________________

Primary Dental Insurance:

Insured Name:______________SS#/ID#:______________ Birthdate:____________

Insurance Co.:______________Group#:______________Employer:______________

Insurance Co. Address:____

Secondary Dental Insurance:

Insured Name:______________SS#/ID#:______________ Birthdate:____________

Insurance Co.:______________Group#:______________Employer:______________

Insurance Co. Address:____

E-mail address: ______________________ May we communicate with you via e-mail for confirmation of appointments? _____Yes _____No (Your email address and phone number will never be shared with a 3rd party.)

Text Message? _____Yes _____No

Please Complete Other Side

Dental/Medical Health History (Confidential)

Your child's overall health as well any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

How often does your child brush/floss? ________________________________

Is your child's water fluoridated? ________________________________

Does your child take fluoride supplements? ________________________________

DOES YOUR CHILD: Suck thumb/Finger_______________ Grind Teeth_______________

Is this your child's first dental visit? ___________ **IF NO,** date of last visit? _______________

Previous Dentist ________________________________

Has your child had difficulty with previous dental visits? ________________________________

Child's Physician ____________________________ Phone # _______________________

Previous Hospitalizations/Surgeries/Serious Illness **When?**

________________________________ ________________________

________________________________ ________________________

Is your child currently taking any medications? _________

(If yes, please list) ________________________________

Is your child allergic to any of the following?

Aspirin___ Penicillin___ Codeine ___ Local Anesthetics ___Latex___ Metal___ **No Known Allergies** ___

Other (if yes, please explain: ________________________________

Does your child have any food allergies? ________________________

IF **YES,** Please list ________________________________

DOES YOUR CHILD HAVE, OR HAS HAD, ANY OF THE FOLLOWING?

___ADHD
___Arthritis
___Blind
___Cerebral Palsy
___Deaf
___Epilepsy
___Gags easily
___Hemophilia
___Kidney Problems
___Rett Syndrome

___AIDS/HIV Positive
___ Asperger's Syndrome
___Breathing Problem
___Chemotherapy
___ Convulsions
___Diabetes
___Fragile X Syndrome
___Hepatitis
___Liver Disease
___Sickle Cell

___Anaphylaxis
___Asthma
___Bruise easily
___Crohns Disease
___Cystic Fibrosis
___Down Syndrome
___Heart Murmur
___High Blood Pressure
___Lung Disease
___Tourette's Syndrome

___Anemia
___Autistic
___Cancer
___Cold Sores/Fever Blisters
___ Congenital Heart Disorder
___ Developmental Delays
___Heart Trouble/Disease
___Irregular Heartbeat
___Mitral Valve Prolapse
___Weaver Syndrome

Other ________________________________ **No Known Conditions** ____

Parent/Guardian Signature ____________________________ **Today's date** _______________

Olentangy Pediatric Dentistry

APPOINTMENT POLICY

The scheduled appointment is reserved specifically for your child. Any change in this appointment affects many patients. If a cancellation is unavoidable, please call the office 24 hours in advance so that we may give that time to another patient.

-We strive to see all patients on time for their scheduled appointment. There are times when our schedule is delayed in order to accommodate a traumatic injury or an emergency. Please accept our apology in advance should this occur during your appointment.

-Please plan to arrive 10 minutes or more before your scheduled appointments. This will allow time to complete any additional paperwork and see your child on time.

-If you arrive 10 minutes late for your appointment, you may be asked to reschedule for the next available appointment time.

-Broken appointments or "No Shows" affect many people. If two (2) broken or missed appointments occur a missed appointment warning letter will be sent. If a third appointment is missed, you will be dismissed from our office and a dismissal letter will be sent.

If at any time you have a question, please feel free to ask our staff or call our office. We are here to help in any way we can. We appreciate you entrusting your child's dental health to us.

Thank you,

Dr. Jeff and Staff

SIGNATURE______________________________________

Olentangy Pediatric Dentistry

Jeffrey Milton D.D.S., M.S.
Colleen Orellana D.D.S., M.S.
Mallary St. John D.D.S., M.S.

FINANCIAL POLICY FOR MEDICAID, CareSource, Molina, Buckeye and United HealthCare Community Plans

Thank you for choosing our office for your child's dental treatment. We are committed to their successful treatment and you need to be too!

PLEASE NOTE: With Medicaid, CareSource, Molina, Buckeye and United HealthCare Community Plans, some procedures are NOT covered under these policies, most commonly, **Oral Sedation** (D9248). Therefore, if your child needs to be treated using Oral Sedation, you will be charged a fee of **$25.00**, which must be paid at the time of the appointment.

If you are unable to keep your appointment, please give us at least 24 hours' notice, otherwise your child will ONLY be able to receive emergency treatment in our office.

By signing this financial policy, you are confirming your understanding that you are the responsible adult for your child(ren). If the policy is not effective for any appointment, you are responsible for the balance, which is expected to be paid immediately.

_______________________________ _______________
Parent/Legal Guardian Date

_______________________________ _______________
Witness – Office Staff Date

Olentangy Pediatric Dentistry

FINANCIAL POLICY

INSURANCE: We are IN NETWORK with Delta Dental Premiere, CIGNA and AETNA. We do accept all insurances and will help you file your insurance claim, however we do not have any agreements with the insurance companies. Insurance policy agreements are set by your employer and the insurance companies **It is your responsibility to call the number listed on the back of your insurance card to verify that our providers are covered under your specific plan. YOU ARE RESPONSIBLE TO KNOW YOUR INSURANCE POLICY.**

DENTAL INSURANCE at time of service:
Any portion of your bill that is not covered by your insurance will be due at the time of treatment. **All co-payments are due at the time of treatment.**
****If your child(ren) is covered by more than one (1) insurance plan, you must give us that information on the day they are treated. We are unable to add this information at a later date once the original claim has been submitted.**

WITHOUT AN INSURANCE CARD at time of service:
If we are able to verify your coverage online before your visit, the same policy as above will be followed. **If we cannot verify your coverage, you will be required to pay in full at the time of your visit.** If after your visit you are able to give us your insurance information in a timely manner, we will bill your insurance and refund your payment less any balance left by your insurance.

NO DENTAL INSURANCE:
Payment is expected in full for each appointment as services are rendered. For the convenience of our patients, we accept cash, personal checks (which CANNOT be postdated), VISA, MC and American Express. Additionally, we offer Care Credit for financing options.

BILLING:
We recognize that under unusual circumstances an account balance may be incurred. Olentangy Pediatric Dentistry requires that all outstanding balances ***be paid in full within 15 days***. We only send two (2) statements for unpaid balances. It is your responsibility to make sure we have up to date mailing address and phone numbers. If your balance remains unpaid and we are unable to reach you, we will send a final notice and then transfer your balance to a third-party collection agency. You may be responsible for any additional fees or charges we incur while attempting to collect your balance. **ANY SCHEDULED APPOINTMENTS WILL BE CANCELLED WITHOUT NOTICE.**

NO SHOWS:
If you are unable to keep your appointment, please give us at least 24 hours' notice or you will be subject to a fee related to the appointment type.

DIVORCED OR SEPARATED PARENTS:
The parent who brings the patient(s) to our office will be responsible for our fees unless specific, alternate arrangements are made in advance, to make payment at time of service.

Thank you in advance for your understanding of our financial policy.

____________________ __________
Parent/Legal Guardian **Date**

____________________ __________
Witness-Office Staff **Date**