CHILD HEALTH HISTORY

Child'sName:____Nickname:_______________________________
First Middle Last

Sex: M____ F_____ Birth date:_______________ Age:____ Reason for visit?______________________

Is this your child's first dental visit?___________ Date of last dental visit?__________________________

What is your child's attitude toward previous dental care?____

Have we seen other children in your family?________ Names____________________________________

Whom may we thank for referring you to our office?____

Is your child adopted?___________

MEDICAL INFORMATION

Is your child under a physician's care now?_______ For what reason?_____________________________

Physician's name____ Ph #:___________________________

Is your child on medication or drugs?___________ What kind?___________________________________
Reason?____

Has your child ever been hospitalized?___________ When?______________
Reason?____

Has your child had a history or difficulty with any of the following?

Premature Birth	Yes.	No☐	Anemia	Yes☐	No☐
Brain Injury	Yes☐	No☐	Speech Disorder	Yes☐	No☐
Heart	Yes☐	No☐	Diabetes	Yes☐	No☐
Cancer or Malignancies	Yes☐	No☐	Hepatitis	Yes☐	No☐
Bone Disorder	Yes☐	No☐	Allergies to Medication	Yes☐	No☐
Rheumatic Fever	Yes☐	No☐	Seizures	Yes☐	No☐
Kidneys	Yes☐	No☐	AIDS	Yes☐	No☐
Bleeding	Yes☐	No☐	Asthma	Yes☐	No☐
Cerebral Palsy	Yes☐	No☐	Liver	Yes☐	No☐

Hearing Yes☐ No☐ Earaches Yes☐ No☐

Gag Reflex Yes☐ No☐

Comments / details____

Does your child have any emotional or school problems?________________________________

DENTAL INFORMATION

Was your child bottle fed? Yes☐ No☐ Until what age?_______

Breast fed? Yes☐ No☐ Until what age?_______

Does your child have any mouth habits, finger/ thumb sucking _____ pacifier_______ other _______

Has your child ever had any injuries to his teeth, mouth or head?______ When?______
Details?____

Does your child brush regularly? Yes☐ No☐ Does an adult assist with brushing? Yes☐ No☐

Does your child floss? Yes☐ No☐ Does an adult assist with flossing? Yes☐ No☐

Have either parent or child been treated orthodontically? Yes☐ No☐

Who has received treatment?____

How would you expect your child to behave in our office?_______________________________

Describe your child: Outgoing____ Shy____ Stubborn____ Anxious____ Frightened____

How may we help to make this visit a positive experience for your child?_____________________

GENERAL INFORMATION

This information is requested for financial and credit purposes.

FATHER(full name)____

Address________________________________ City___________________State______ Zip______

Best Ph #___________ SS#_____-______-______ Birth date____________ Marital Status:_______

Employer__________________________ Work Ph #_______________ Cell Ph #_______________

Address________________________________ City___________________State______ Zip______

Email Address______________________@_______________ Driver License #_________________

MOTHER(full name)____

Address________________________________ City___________________State______ Zip______

Best Ph #___________ SS#_____-______-______ Birth date____________ Marital Status:_______

Employer__________________________ Work Ph #_______________ Cell Ph #_______________

Address________________________________ City___________________State______ Zip______

Email Address______________________@_______________ Driver License #________________

Name of nearest relative_____________________ Home Ph #__________ Work Ph #___________

Relation to which parent and relation to patient____

INSURANCE INFORMATION

PRIMARY DENTAL INSURANCE

Name of subscriber_________________________Subscribers ID____________ Grp. No._________

Name of Insurance Co. _______________________________________ Ph #__________________

Address________________________________ City___________________State______ Zip______

Policy holders employer____

SECONDARY DENTAL INSURANCE

Name of subscriber_________________________Subscribers ID____________ Grp. No._________

Name of Insurance Co. _______________________________________ Ph #__________________

Address________________________________ City___________________State______ Zip______

Policy holders employer____

Assignment of Benefits: I authorize Dr. Bertolini to furnish my insurance company with all the information to process my dental claims. I authorize the above named insurance company to pay all benefits due me directly to Dr. Bertolini. I understand I am responsible for charges not covered by this assignment.

Our financial policy is to receive payment in full by the time treatment is completed. If this is not convenient for you, we do accept VISA, Discover, Mastercard and can direct you to other sources of credit. If you have dental insurance, we will submit your claim and you will be billed for any remaining balance not paid by your insurance company.

SIGNATURE:____DATE:_____________

Signature/ Guardian (if under 18 years old)

Financial Policy

FULL PAYMENT IS DUE AT TIME OF SERVICE

Our office gladly accepts Visa, MasterCard, Discover, cash, personal checks, and CareCredit.
If you would like to apply for CareCredit financing, please consult our front office staff.

For Patients With Insurance

As a courtesy to our patients with insurance, we will file your dental claims for services rendered. Any amount not paid by insurance is your responsibility. We will be happy to file a pre-determination to the insurance company so we can get a more accurate estimate of what they should pay, but it is still not a guarantee of their payment. You are responsible for paying any deductible and copayment at the time of service. Once we receive payment from the insurance company, you will be required to pay any balance due upon receipt of your statement. The balance due for services provided is the patient's responsibility, even if the insurance company pays nothing. If you have overpaid your portion, you may request a refund or use the credit for additional work that may be needed.

Delinquent Accounts

If in 30 days your balance remains unpaid, we reserve the right to add 18% annual interest to the unpaid balance.
We reserve and will exercise the right to report any account 90 days past due to a Collection Agency. All expenses incurred as a result will be the patient's responsibility, as permitted by law.

Cancellations & Missed Appointments

Appointments are valuable blocks of time and when an appointment is broken or canceled with short notice, we are often prevented from filling that time and helping other patients. Please give at least ***24 business hours notice*** when you will not be able to make your scheduled appointment. This will allow us time to help other patients and helps keep costs down. We reserve the right to charge for all broken or canceled appointments with less than the required 24 business hour notification. Additionally, if you are more than 15 minutes late for an appointment, you may be asked to reschedule.

All Patients Please Sign

By signing below, I certify that I have read, understand, and agree to this policy.

Patient Signature ____ Today's Date________________

Appendix 2.3.2

Acknowledgement of Receipt of Notice of Privacy Practices

* You May Refuse to Sign This Acknowledgment*

Francis A. Bertolini, DDS FAGD

I have received a copy of this office's Notice of Privacy Practices.

Print Name:____

Signature:____

Date:____________________Email:____

Please check which phone # you'd prefer to be reached:

- ☐ Home #:(____)_____________ ☐ May we leave you a message?
- ☐ Cell #: (____)_______________ ☐ May we leave you a message? ☐ May we text appointment reminders?

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other - Please Specify:

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Francis A Bertolini, DDS

Photographic Release

I consent and agree to the use, reproduction or otherwise published photograph of me in any publication or lecture presentation of this doctor. Dr. Bertolini or any other person authorized by him has the right to use such images in any advertising and promotion of such publication and the dispositions of all rights thereto. Your name will not be used with your image.

________ (initials)

I further agree I will not assert any claims against any party whatsoever based on the usage of the images or make any claim to the use of the images defaming me or constitutes an infringement on my right to privacy or any other right I may enjoy.

________ (initials)

To our No Cavity Club Winners: We want to ***celebrate*** our young patients' cavity free smiles, which is why we photograph Dr. Bertolini with our winners & with your permission we post on Facebook and Instagram.

*We respect your privacy, our office will **never** post your child's first or last name.*

Thank you!

The Francis A. Bertolini, DDS Dental Team

follow us **@NorthCantonSmiles**

____

Patient Name

______________________________ ______________

Signature/ Guardian (if under 18 years old) Date