



PEDIATRIC DENTISTRY, DOUGLASVILLE

JOHN B. HEILMAN, D.D.S.

(770) 942-1260

Today's Date: _____

Please fill in the personal health history on the following pages. This information is an important aid in making a thorough evaluation of your child's dental health. It also allows us to more adequately plan for your child's emotional and dental needs. This important document, therefore, becomes an integral part of our continuing evaluation of your child's growth and development in these formative years.

Our thanks for your cooperation.

Full name of child _____ "Nickname" if used _____

Age _____ Birthday _____ Sex _____ Address _____

City _____ State _____ Zip _____ Referred by _____

Parent's first name (Father) _____ (Mother) _____

Father's Work Phone _____ Mother's Work Phone _____ Home Phone _____

Name and birthdates of other children: _____

Family Dentist _____ Phone _____

Child's Physician _____ Phone _____

Date and reason for recent medical exam: _____

Name(s) of any medication(s) taken recently by your child: _____

Condition of child's health: _____

Has your child ever been allergic to any medicine, food, or substance? _____

Has your child ever bled excessively from a cut or injury, or bruised easily? _____

Has your child had (Circle if yes)

- Heart Disease, Rheumatic Fever, Liver Disease, Kidney Disease, Brain Injury, Glandular Problems,
- Asthma, Respiratory Disease, Frequent Colds, Digestive Disorders, Blood Disease, Hepatitis, HIV,
- Mental or Physical Handicap.

Please indicate any health problems not listed above. _____

Has your child ever been hospitalized? _____ Give Details: _____

How does your child accept his/her physician? _____

Was the term of pregnancy and birth normal with respect to your child? _____

If no, please state any complications or problems including prematurely or low birth weight. _____

What is your main reason for bringing your child to this office? _____

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

If not, when was last visit? _____ How well was treatment accepted? _____

How would you describe your child's temperament? _____

Does your child have a history of: (Circle)

Thumb Sucking, Mouth Breathing, Nail or Object Biting, Bed-Wetting, Tongue-Thrusting, Speech Problem

Has any member of your family had any unusual dental problem? _____

Has there ever been any injury to any of the teeth? _____

Has your child ever had any unfavorable reaction to local anesthesia? _____

How often does your child brush his/her teeth? _____ Times a day _____

After every meal _____ Before bedtime _____ Supervised _____

Has your child had fluoride treatments of any sort? _____

Name of vitamin taken at present _____ Age of child when off bottle _____

Walked _____ Talked _____ First Tooth _____

Name and grade school _____

Child's interests, hobbies, talents, etc. _____

Please list any questions you would like to have answered _____

May we request release of your child's medical records for our reference? _____ Yes _____ No

Because _____ is a minor, it becomes necessary that signed permission is obtained from a parent or guardian before any and/or all necessary dental services and methods can be rendered. Furthermore, undersigned will be responsible for any fee incurred on the above child for dental treatment rendered.

Authorization is hereby guaranteed as such:

Date Parent / Guardian

Date

Today's Date: _____

Patient Information:

Home Phone: _____

Last Name _____ First _____ Middle _____

Street Address/Apt _____

City _____ State _____ Zip _____ Birthday _____

Name of Emergency contact not living in your home:

Name _____ Address _____

City _____ State _____ Zip _____ Home Phone _____

Work Phone _____

Parent/Guardian Responsible for Payment or Primary Insurance Carrier:

Last Name _____ First _____ Middle _____

Street Address/Apt _____

City _____ State _____ Zip _____ Home Phone _____

SS# _____ Birthday _____ Work Phone _____

Dad's SS# _____ Dad's Birthday _____

Dad's Employer _____ Work Phone _____

Employer Address _____ City _____ ST _____ Zip _____

Mom's SS# _____ Mom's Birthday _____

Mom's Employer _____ Work Phone _____

Employer Address _____ City _____ ST _____ Zip _____

Primary Insurance Co. _____ Group # _____ Phone _____

Address _____ City _____ ST _____ Zip _____

Secondary Insurance Co. _____ Group # _____ Phone _____

Address _____ City _____ ST _____ Zip _____

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT VISA AND MASTERCARD FOR YOUR CONVENIENCE. You are responsible for any balance after insurance. Your signature below indicates that you understand and accept this policy. Further, your signature authorizes the Doctor to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of dental benefits to the Doctor when an assigned claim is filed.

Should I still have a balance owned after 60 days, I authorize that unpaid balance to be charged to my major credit card, as listed below:

VISA - MasterCard (please circle one) # _____ Exp. Date: _____

Name as it appears on the card: _____ Signature _____

If no credit card, your part of the charges are due at time of treatment.

Signature of Parent or Legal Guardian

Date

Office Policy:

1. We see our patients by appointment only and your child's time is exclusively reserved. Therefore, we must charge you for missed appointments if you do not give us 24 hours advance notice. Regretfully, if your child fails his/her appointment time, it prevents another child from being seen, who may have a severe dental problem. The charge for the first broken appointment is \$30.00. Repeated failures will place your child on inactive status requiring a deposit fee or a standby-by appointment basis.
2. Dental insurance is filed by our office, but please be aware that you are the one charged for our service and all costs not paid for by the insurance company.
3. Cash, check and bank cards are the only acceptable forms of payment. Payment is due at the time of treatment. Financing is available through Care Credit (3rd party).
4. Child management procedures are not included in regular dental fees. A fee is charged if your child's treatment requires behavior management with oral sedation, given at home or at the office, which is not uncommon for children age six and under with serious dental problems.
5. Parents are allowed to accompany their pre-school age children to the treatment room if necessary for their initial dental visit. However, during treatment, only the patient (child) is permitted in the treatment room. Upon request, we will let you know how well your child is doing and will inform you of any treatment changes that occur.
6. There will be a charge for more than one insurance form and for itemized statements for accidents, accountants, income tax, etc.
7. Please feel free to ask any questions you may have of our staff or to Dr. Heilman at any time.

Parent/Guardian

Date