HUNTINGTON PEDIATRIC DENTAL GROUP

Kevin J. Snaer, D.D.S., Inc.
Diplomate, American Board
of Pediatric Dentistry

Welcome! How did you choose our office? ______________________________
NAME OF PERSON OR OTHER SOURCE

Do we see other family members? ______________________________

PARENTS' NAMES: ______________________ ______________________
____ MRS. ____ MS. ____ MR. ____ DR. ____ MRS. ____ MS. ____ MR. ____ DR.

ADDRESS: ______________________ ______________________
STREET STREET
______________________ ______________________
CITY ZIP STATE CITY ZIP STATE

PHONE: ______________________ ______________________
HOME HOME
______________________ ______________________
MOBILE MOBILE

E-MAIL ADDRESS: ______________________ ______________________

OCCUPATION: ______________________ ______________________
POSITION OR HOMEMAKER POSITION OR HOMEMAKER
______________________ ______________________
COMPANY COMPANY
______________________ ______________________
STREET STREET
______________________ ______________________
CITY ZIP STATE CITY ZIP STATE
______________________ ______________________
PHONE PHONE

DATE OF BIRTH: ______________________ ______________________

SOCIAL SECURITY: ______________________ ______________________

INSURANCE CO: ______________________ ______________________

GROUP & I.D. #: ______________________ ______________________

ADDRESS ACCOUNT STATEMENT TO: ______________________________
PARENT NAME

____

RELEASE OF DENTAL EXAMINATION/TREATMENT INFORMATION.
ASSIGNMENT OF INSURANCE BENEFITS, AND
DISCLOSURE OF FINANCE CHARGE ON OVERDUE ACCOUNTS.
AUTHORIZATION FOR CREDIT CHECK.

1. I take full responsibility for this account. If the amount which will be paid by insurance is important in determining the choice of treatment, I will find out this information before starting treatment.
2. In requesting examination and/or treatment on or after this date, I authorize the release of all information (including x-rays) relating to such examination or treatment to any health service plan or insurance company from which benefits have been paid or may be payable.
3. I also authorize the release of such information to any peer review committee of the state or local associations which may request it.
4. I hereby authorize payment directly to Kevin J. Snaer, D.D.S., Inc. of the group insurance benefits otherwise payable to me, but not to exceed his actual charges for the covered services. I understand that any overpayment caused by my previous personal payment will be promptly refunded to me.
5. I understand that interest-free monthly payment arrangements may be made. I also understand that if no monthly payment arrangements have been made, amounts for which more than one monthly statement has been sent will be subject to a 1 ½ % per month (18% Annual Percentage Rate) finance charge.
6. I understand that a credit report may be secured for the purpose of establishing my account and that no charge will be made to me for such a report.

______________________ ______________________________
DATE **SIGNATURE**

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CHILD'S NAME: ____________________ NICKNAME: ______________ BIRTHDATE: ____________

CHILD'S PHYSICIAN: ______________________________________ LAST EXAM: ____________

HAS THE PATIENT BEEN TO ANOTHER DENTAL OFFICE? ☐ YES ☐ NO ______________________

NAME OF DENTIST WHERE AND WHEN

MEDICAL HISTORY UPDATE	YES	NO	(Please Explain YES Answers)
1. Has child ever been treated for illness other than childhood diseases?	☐	☐	
2. Does child have any emotional, neurological, or other special health care needs?.	☐	☐	
3. Does child take any medication on regular schedule?	☐	☐	
4. Have any of the following ever been defective: Eyes, Ears, Heart, Lung, Kidney, Liver?.	☐	☐	
5. Has child ever had an allergic reaction to any drug, medicine, or anesthetic?	☐	☐	
6. Is child allergic to anything?	☐	☐	
7. Does child bleed excessively or bruise easily?	☐	☐	

______________________ ______________ ________ ______________

SIGNATURE **RELATIONSHIP** **DATE** **REVIEWER**