# 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

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**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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**HUNTINGTON PEDIATRIC DENTAL GROUP**
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CHILD'S NAME: _____ NICKNAME: _____ BIRTHDATE: _____

CHILD'S PHYSICIAN: _____ LAST EXAM: _____

REASON FOR MAKING THIS APPOINTMENT: _____

| **MEDICAL HISTORY** | **Please Explain YES Answers** | **YES** | **NO** |
|---|---|---|---|
| 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 drugs, medicine, or anesthetic? | | ☐ | ☐ |
| 6. Is child allergic to anything? | | ☐ | ☐ |
| 7. Does child bleed excessively or bruise easily? | | ☐ | ☐ |

**DENTAL HISTORY**

**Diet**

| | | | |
|---|---|---|---|
| 1. Did your child regularly feed within 30 minutes of bed time? If so, until what age? | | ☐ | ☐ |
| 2. Did your child regularly feed during the night? If so, until what age? | | ☐ | ☐ |
| 3. Is your child snacking more than one time between meals? | | ☐ | ☐ |
| 4. Is your child drinking juice between meals? | | ☐ | ☐ |

**Fluoride**

| | | | |
|---|---|---|---|
| 1. Has your pediatrician prescribed a fluoride supplement? | | ☐ | ☐ |
| 2. What is the name of your city and your water company? | | | |
| 3. Does your child drink tap or bottled water primarily? | | | |
| 4. If your child drinks tap water, do you have a reverse osmosis filter? | | ☐ | ☐ |
| 5. If your child drinks bottled water, is it fluoridated? | | ☐ | ☐ |
| 6. How many ounces of water is your child drinking per day? | | | |
| 7. Is your child using toothpaste with fluoride? | | ☐ | ☐ |

**Hygiene**

| | | | |
|---|---|---|---|
| 1. How do you position your child for brushing and flossing? | | | |

**Jaw Growth**

| | | | |
|---|---|---|---|
| 1. Has your child had a thumb, finger or pacifier sucking habit past the first birthday? If so, describe: | | ☐ | ☐ |

| SIGNATURE | RELATIONSHIP | DATE | REVIEWER |
|---|---|---|---|

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