WELCOME

1 About Your Child

Today's Date: ____/____/____ File #: __________

Child's Name: ______________________________
LAST FIRST M.I.

Child's Nickname: ______________ ❑ Boy ❑ Girl

Child's Birthdate: ____/____/____ Age: ________

School: ______________________ Grade: ______

Child's Home Phone #:(______) ______________

Child's SS#: ______________________________

Child's Address: ___________________________
HOME ADDRESS

____
CITY STATE ZIP

Referred By: ______________________________
(If doctor, please give address & phone number.)

____

2 Insurance Information

Primary Dental Insurance

Co. Name: ______________________________

Address: ______________________________

____
CITY STATE ZIP

Phone #: ______________________________

Insured's ID#: ___________________________

Group # (Plan, Local, or Policy #): __________

Insured's Name: __________________________

Relation: ____________ Date of Birth: ___/___/___

Insured's Employer: _______________________

Does either policy cover Orthodontics? ❑ Yes ❑ No

Secondary Dental Insurance

Co. Name: ______________________________

Address: ______________________________

____
CITY STATE ZIP

Phone #: ______________________________

Insured's ID#: ___________________________

Group # (Plan, Local, or Policy #): __________

Insured's Name: __________________________

Relation: ____________ Date of Birth: ___/___/___

Insured's Employer: _______________________

3 Child's Family Information

Who is accompanying this child today?

______________________________ ______________
FULL NAME (IF OTHER THAN PARENT) RELATION TO CHILD

Do you have Legal Custody of this Child? ❑ Yes ❑ No

How many Brothers/Sisters? ______ Age(s): _____ _____ _____

Mother's Name: ______________________________
❑ STEP MOTHER ❑ GUARDIAN

____
(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(______) ______________ (______) ______________ ______
HOME PHONE # WORK PHONE # EXT.

______________ ___/___/___ ______________
MOTHER'S SOCIAL SECURITY # DATE OF BIRTH MOTHER'S DRIVERS LIC. #

Employer: ______________________ How Long? ______

____
EMPLOYER'S ADDRESS CITY STATE ZIP

Father's Name: ______________________________
❑ STEP FATHER ❑ GUARDIAN

____
(❑ **CHECK IF SAME AS CHILD'S)** HOME ADDRESS CITY STATE ZIP

(______) ______________ (______) ______________ ______
HOME PHONE # WORK PHONE # EXT.

______________ ___/___/___ ______________
FATHER'S SOCIAL SECURITY # DATE OF BIRTH FATHER'S DRIVERS LIC. #

Employer: ______________________ How Long? ______

____
EMPLOYER'S ADDRESS CITY STATE ZIP

4 Account Information

Person ultimately responsible for account

Name: ______________________ ______________
RELATION TO CHILD

Billing Address: ___________________________

____
CITY STATE ZIP

______________ ___/___/___ ______________
SOCIAL SECURITY # DATE OF BIRTH DRIVERS LIC. #

(______) ______________ ______ (______) ______________
WORK PHONE #: EXT. CELL PHONE #:

Payment method: ❑ Cash ❑ Check

______________________________ _____/_____

❑ Credit Card - Enter card # above (if accepted)

________ I hereby authorize assignment of my insurance rights and
Initials benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company (if offered at this office).

Please Continue On Back

5 Child's Dental Information

Reason for today's visit: ☐ Exam ☐ Emergency ☐ Consultation

Is Child in pain? ☐ No ☐ Yes How Long? ____________

Please indicate ☑ any of the following problems:

☐ Discomfort, clicking or popping in jaw. ☐ Lost/Broken Filling(s) ☐ Stained teeth
☐ Red, swollen or bleeding gums. ☐ Teeth grinding ☐ Locking Jaw
☐ Sensitive tooth, teeth or gums. ☐ Ringing in Ears ☐ Bad breath
☐ Blisters/Sores in or around the mouth. ☐ Broken/Chipped tooth ☐ Loose tooth
☐ Other(s): ____________

Does child require pre-medication? ☐ Yes ☐ No ☐ Don't know

Previous Dentist: ____________ (____) ____________

Last Dental exam: ____ / ____ / ____ Last Dental X-rays: ____ / ____ / ____

Times a day child brushes? ______ Times a week child flosses? ______

Is the child's water fluoridated? ☐ Yes ☐ No

How would you rate the child's smile? **Best** 1 2 3 4 5 6 7 8 9 10 **Worst**

6 Child's Medical History

Is Child taking any of the following medications? ☐ Pain killers (INCLUDING ASPIRIN) ☐ Ritalin ☐ Stimulants
☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Muscle relaxers ☐ Others: ____________

Child's Physician: ____________ (____) ____________
DOCTOR'S NAME OR CLINIC NAME PHONE#

____________ Last Medical Exam: ____ / ____ / ____
ADDRESS CITY STATE ZIP

Does Child have or ever had any of the following diseases, medical conditions or procedures?

Y N Heart Murmur	**Y N** Tonsillitis	**Y N** High/Low Blood Pressure
Y N Rheumatic fever	**Y N** Respiratory Problems	**Y N** Hepatitis
Y N Artificial Heart Valves	**Y N** Asthma/Difficulty Breathing	**Y N** Artificial Bones/Joints/Implants
Y N Congenital Heart defect	**Y N** Blood Transfusion(s)	**Y N** Liver/Kidney/Organ Problems
Y N Scarlet Fever	**Y N** Leukemia/Anemia	**Y N** HIV+/AIDS/ARC
Y N Surgeries/Operations	**Y N** Diabetes/Hypoglycemia	**Y N** Tuberculosis TB
Y N Cancer/Tumors	**Y N** Hemophilia	**Y N** Psychiatric Problems
Y N Chemotherapy	**Y N** Abnormal Bleeding	**Y N** Hyper Active/ADD
Y N Jaw Problems TMJ/TMD	**Y N** Cleft Lip/Palate	**Y N** Fainting/Seizures/Epilepsy
Y N Hearing Problems	**Y N** Birth Defects	**Y N** Cerebral Palsy

Please list any other medical condition(s) child has or ever had: ____________

Is Child allergic to: ☐ Latex ☐ Penicillin/Amoxicillin ☐ Tetracycline ☐ Dental Anesthetics (Novocaine)
☐ Aspirin ☐ Food allergies ☐ Other(s): ____________

Please rate the child's general health from 1-10: ______ Does child wear contact lenses? ☐Yes ☐No

Has this child ever taken the drug Ritalin? ☐ No ☐ Yes/How long? ______ Child's Blood type: ______

Does this child do any of the following? ☐ Thumb/Finger Sucking ☐ Tongue Thrusting/Sucking
☐ Heavy Snoring ☐ Mouth Breathing ☐ Lip Sucking/Biting

- We invite you to discuss with us any questions regarding our services. The best Dental health services are based on a friendly, mutual understanding between provider and patient.
- Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made with the business manager. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.
- I authorize the staff to perform any necessary services needed during diagnosis and treatment. I also authorize the provider to release any information required to process insurance claims.
- I understand the above information and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

Signature ____________ Date ___ / ___ / ___
☐ Parent or Guardian ☐ Other:

UPDATE
(OFFICE USE)

____ Initials ___ / ___ / ___ Date
Comments

____ Initials ___ / ___ / ___ Date
Comments

____ Initials ___ / ___ / ___ Date
Comments

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Financial Policy

This is an agreement between Drs. Oswald, Siedlecki and John C. Oswald DDS, Inc., an Ohio Professional Corporation, as creditor, and the Patient/Debtor named on this form.

In this agreement the words "you," "your," and "yours" mean the Patient/Debtor. The word "account" means the account that has been established in your name to which charges are made and payments credited. The words "we," "us," and "our" refer to Drs. Oswald, Siedlecki and John C. Oswald DDS, Inc.

By executing this agreement, you are agreeing to pay for all services that are received.

Payment options if you have no insurance:

A. You may choose to pay by ___ cash, ___ check, or ___ credit card on the day that treatment is rendered.
B. On treatment involving laboratory fees (crowns, bridges, dentures, etc.) you may choose to pay 50% on the preparation date and the balance in two weeks.
C. On extensive treatment you may prefer to secure a bank, credit union, or other third party financing for the entire treatment.
D. We also offer special financing with 0-6% interest.

Payment options if you have insurance:

A. You may choose to pay your deductible of $ ________ and any out-of-pocket portions at the time services are rendered ___ cash, ___ check, or ___ credit card.
B. You may choose to pay all of your treatment by ___ cash, ___ check, or ___ credit card. We will request your insurance carrier send their payment directly to you.
C. On extensive treatment (crowns or bridges) you may choose to pay 50% of your out-of-pocket portion on the start or preparation date, and the balance on the completion date or delivery date. (Normally two weeks later.) We also offer special financing with 0-6% interest.

Required payments: Any co-payments required by an insurance company must be paid at the time of service. Because this is an insurance requirement, we cannot bill you for these.

Payments: Unless other arrangements are approved by us in writing, the balance on your statement is due and payable when the statement is issued, and is past due if not paid within two weeks.

Monthly Statement: If you have a balance on your account, we will send you a monthly statement. It will show separately the previous balance, any new charges to the account, the finance charge, if any, and any payments or credits applied to your account during the month.

Charges to Account: We shall have the right to cancel your privilege to make charges against your account at any time. Future visits would then need to be paid at the time of service.

The Financial Policy continues on the back side of this page.

Patient's name: ______________________________

Signature: ______________________________ Date: ________________

Co-Signature: ______________________________ Date: ________________

White copy - Dental Office   Yellow copy - Patient

Insurance:

Insurance is a contract between you and your insurance company. We are NOT a party to this contract.

We will bill your primary insurance company as a courtesy to you. If we have not received a reply from your insurance carrier within ninety (90) days, it will be your responsibility to pay for the services rendered on the date in question. Then it will be your responsibility to contact your insurance carrier regarding that date of service. Although we may estimate what your insurance company may pay, it is the insurance company that makes the final determination of your eligibility. You agree to pay any portion of the charges not covered by insurance. If your insurance company requires a referral and/or preauthorization, we will help you to obtain it. Failure to obtain the referral and/or preauthorization may result in a lower payment from the insurance company.

Credit History: You give us permission to check your credit and employment history and to answer questions about your credit experience with us. We have the option to report your account status to any credit reporting agency such as a credit bureau.

Returned checks: There is a fee (currently $28.00) for any checks returned by the bank.

Missed appointment fee: Patients who do not show up for two (2) consecutive appointments, or cancel with less than 24 hours notice will be charged a $48.00 fee. This fee must be paid before another appointment is scheduled and then it will be credited to your account, provided you show up on time.

Past due accounts: If your account becomes past due, we will take necessary steps to collect this debt. If we have to refer your account to a collection agency, you agree to pay all of the collection costs which are incurred. If we have to refer collection of the balance to a lawyer, you agree to pay all lawyer's fees which we incur plus all court costs. In case of suit, you agree the venue shall be in Cuyahoga County, Ohio.

Waiver of confidentiality: You understand if this account is submitted to an attorney or collection agency, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

Workers' Compensation: We currently do not provide this compensation. We will be happy to refer you to another providing office.

Personal Injury: If you are being treated as part of a personal injury lawsuit or claim, we require verification from your attorney prior to your initial visit. In addition to this verification, we require that you allow us to bill your dental insurance. In the absence of insurance, other financial arrangements may be discussed. Payment of the bill remains the patient's responsibility. We cannot bill your attorney for charges incurred due to a personal injury case.

Co-signature: If this or another Financial Policy is signed by another person, that co-signature remains in effect until canceled in writing. If written cancellation is received, it becomes effective with any subsequent charges.

Effective Date: Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

JOHN C. OSWALD, D.D.S., INC.
JODIE D. SIEDLECKI, D.D.S.
GENERAL DENTISTRY

5885 STATE ROAD
PARMA, OHIO 44134
Telephone (440) 886-1916
Fax (440) 885-7114

PARENT/GUARDIAN VERIFICATION/CONSENT

I, as the parent/ legal guardian of ____,
my child(ren), voluntarily delegate my legal authority to basic dental care (exam, routine annual x-rays, routine fluoride treatment, cleaning, and oral hygiene instruction) on behalf of my minor child (ren) to John C. Oswald D.D.S., Inc., whose number and address is listed above.

This consent is to be exercised in good faith and in the best interest of my child(ren), subject to the following conditions (if any):

____

____

____

____

This consent is to be effective as of today or otherwise for the period of time, which I will not be reasonably available to make such decisions for my child(ren).

I do authorize the following named authority to make dental care decisions fo the above mentioned minor(s) in my absence:

____

____

____

Signature of parent/guardian_________________________Today's Date__________

Current Address:____

Telephone and/ or cell phone number to be reached in case of an
emergency____

please inform this office of any changes which need to be made to this document by parent/guardian.