Golnick Pediatric Dental Associates

21213 Ecorse Road	2300 Haggerty Road #1180
Taylor, MI 48180	West Bloomfield, MI 48323
313-292-7777	248-668-0022
Fax (313) 292-7515	Fax (248) 668-2162

Welcome to our office. It is important to completely fill out this questionnaire for your child. All information is confidential and will not be released to anyone without your consent. Please print clearly. Any question, please ask. Thank you.

Child's Personal Information

Child's Name (last) ___________________________ (first) ______________________________ (nickname) ___________________________________

Date of Birth _____________________________ **Gender** (circle one): male female **Weight**_______________________________

Physician (Name) ___________________________ (City) ______________________________________ (Phone) __________________________________

Pharmacy (Name) ___________________________ (City) ______________________________________ (Phone) __________________________________

Child's Favorite (Sport) ___________________________ (Toy) ______________________________ (Hobby) __________________________________

Child's Medical Health Evaluation

Please circle Yes or No for each question

Yes No 1. Is your child in good health? Date of last medical exam?____

Yes No 2. Is your child currently under the care of a physician?

If yes, for what? ____

Yes No 3. Has your child ever been hospitalized for any serious illnesses? Any surgery performed?

If yes, please explain ____

Yes No 4. Is your child allergic to or had an allergic reaction to any drugs, medications, or latex?

If yes, please specify ____

Yes No 5. Is your child taking any prescription or non-prescription drugs, medicines, or pills?

If yes, please specify ____

6. Does your child have or had any of the following diseases, illnesses or medical problems?

Heart Murmur / Rheumatic Fever	Yes	No	Thyroid Problems	Yes	No	Sinus Problems	Yes	No
Kidney Problems / Urination	Yes	No	Blood Disorders / Anemia	Yes	No	Seizures / Epilepsy	Yes	No
Hepatitis / Liver Problems	Yes	No	Asthma / Breathing / TB	Yes	No	Diabetes / Sugar	Yes	No
Attention Deficit Disorder (ADD)	Yes	No	Hyperactivity	Yes	No	Colitis / Ulcer	Yes	No
Deafness / Hearing	Yes	No	Blindness / Vision	Yes	No	Heart Problems	Yes	No
Mitral Valve Prolapse	Yes	No	Artificial Joints / Pins	Yes	No	Herpes / Cold Sores	Yes	No
Premature Birth	Yes	No	Complications at Birth	Yes	No	Cancer / Tumors	Yes	No
Radiation therapy (x-rays)	Yes	No	Reflux / Stomach Disorders	Yes	No	Prolonged bleeding	Yes	No

Yes No 7. Has your child ever been exposed or diagnosed with HIV or AIDS?

Yes No 8. Has your child ever had to seek psychological or psychiatric counseling?

Yes No 9. Does your child smoke or use smokeless tobacco? If yes, how many packs / day? ________________

Yes No 10. Does your child have a learning disability or attend a special school?

If yes, please explain ____

Yes No 11. Any further comments regarding your child's medical condition we should know about?

If yes, please explain ____

Yes No 12. Is your child pregnant? If yes, when in the expected due date? ____________________________________

Are there any additional comments regarding your child's medical health you would like to share with us?

Continued on back

Child's Dental History

Why did you bring your child to our office today? ____

____

Please circle Yes or No for each question

Yes No 1. Is this your child's first visit to a dentist?

If no, when was last dental visit? ____________ Dentist's name? ____________ (city) __________

Yes No 2. Is your child complaining of any discomfort at this time?

If yes, please explain ____

Yes No 3. Has your child ever had a filling or tooth removed?

Yes No 4. Has your child ever received local anesthetic ("had their tooth put to sleep)?"

If yes, what was their reaction? ____

Yes No 5. Has your child ever had nitrous oxide (laughing gas)?

Yes No 6. Does your child have any loose teeth?

Yes No 7. Does your child's gums bleed when they brush / floss?

Yes No 8. Do you brush your child's teeth? If yes, how often? ____________________

Yes No 9. Does your child brush his/her own teeth? If yes, how often? ________________

Yes No 10. Do you or your child use dental floss when cleaning the teeth? If yes, how often? __________

Yes No 11. Does your child snack in between meals? Favorite snack(s)? ____________________

Yes No 12. Does your child have any popping, clicking or pain around their ears or jaw joint?

Yes No 13. Does your child grind or clench their teeth? If so, when? ________________________

Yes No 14. Any past or planned orthodontic treatment (i.e. braces)? Name of Orthodontist? ____________

Yes No 15. Does your child have any oral habits? Pacifier Nursing Bottle Thumb / finger sucking Nail biting

Yes No 16. Does your child have any speech problems? If yes, explain ________________________

Yes No 17. Is your drinking water filtered, from a well, or from a bottled source?

Yes No 18. Does your child use fluoride? Please circle: Tablets Vitamins Toothpaste Varnish Professional topical applications

Yes No 19. Does your child participate in contact sports (i.e. hockey, soccer, football, etc.)?

Yes No 20. Any unhappy dental experiences? If yes, explain____________________________

Yes No 21. Do you anticipate your child having difficulty accepting dental treatment?

Any additional comments ____

I agree that my child's physician and/or previous dentist may be contacted to complete details of their medical and dental histories , if required. __________ Parent / Guardian initials

OFFICE POLICY

Your appointment time will be reserved especially for you and your child. If you are unable to keep your appointment, we require 24 hours notice, otherwise it may be necessary to charge you for the lost time.

Payment is due at the time services are provided, unless other arrangements have been made prior to the beginning of treatment. We gladly accept payment from your dental insurance, however, you are ultimately responsible for all dental charges. It is your responsibility to understand your own insurance coverage, deductibles, and eligibility.

CONSENT FOR DENTAL TREATMENT

The information completed on this form is correct to the best of my knowledge. I (parent / guardian) ____________________ understand that all medical and dental information will be held in confidence. I hereby consent to the performing of dental procedures necessary or advisable for my child (name) ________________, and I accept responsibility for the charges. I agree to the office policy as stated.

Parent / Guardian Signature ______________________________ **Date** ____________________

HEALTH HISTORY UPDATE

Have there been any changes in your child's health or medications since the last update?

Yes No Date________ Comments______________________________ Signature ______________

Yes No Date________ Comments______________________________ Signature ______________

Yes No Date________ Comments______________________________ Signature ______________

Yes No Date________ Comments______________________________ Signature______________

Demographics and Insurance Disclosure

Child's Name:__________________________Social Security #:________________

Date of Birth:______________________ Gender (circle one): Male Female

Child's Address(Street):____

(City)_________________________________ (State)_____ (Zip Code)__________

Referred by: (Name)_____________________________ (City)__________________

Father's Name:_________________________ Date of Birth:_________________

SS #(father):_______________________ (Circle one): Married Single Divorced

Address:____

Telephone (home):_________________________ (work):______________________

Cell / Alternate Phone #:____

Employer (father):___________________ E-mail ___________________________

Ins. Co. (dental):___________________________ (policy #) _______________________

Mother's Name:_________________________ Date of Birth:_________________

SS #(mother):_______________________ (Circle one): Married Single Divorced

Address:____

Telephone (home):_________________________ (work):______________________

Cell / Alternate Phone #:____

Employer (mother):___________________ E-mail ___________________________

Ins. Co. (dental):___________________________ (policy #) _______________________

****If Parent Not Responsible for Insurance and Payment**

Guardian's Name:_______________________ Date of Birth:_________________

Address:____

Telephone (home):_________________________ (work):______________________

Cell / Alternate Phone #:____

SS #(guardian):______________________ (Circle one): Married Single Divorced

Employer (guardian):___________________ E-mail ___________________________

Ins. Co. (dental):___________________________ (policy #) _______________________

Dr. Arnold Golnick **Dr. Jason Golnick**
Dr. Michelle Tiberia **Dr. Andreina Castro**
Dr. Gail Molinari

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Dear Patient,

Due to the constant changes in insurance policies, it is no longer an easy task to interpret individual coverage and determine financial responsibilities. Although we strive to stay aware of policy changes, it is not always possible and very difficult.

Thus, it is your responsibility to understand your own insurance coverage. Any questions about your coverage, deductibles, or insurance policies should be directed toward your insurance carrier and employer.

Failing to comply with this suggestion could result in you, the legal guardian or responsible party, being responsible for all costs incurred. Please remember, your insurance policy is an agreement between you and your employer or company and not with the insurance company and your doctor. Keeping this in mind, we will attempt to aid you in resolving conflicts whenever possible.

Your appointment time will be reserved especially for you and your child. If you are unable to keep your appointment, we require 24 hours notice, otherwise you will be charged at least twenty-five dollars per every thirty minute appointed.

All co-payments, deductibles, behavior management fees and any unpaid balances must be paid in full before any treatment or services are provided. We accept credit cards, checks, and cash. Payment arrangements may be made in advance.

If your account becomes delinquent and a collection agency becomes involved, all fees assessed by the collection agency or legal representation will be your responsibility. **Additionally, once your account becomes delinquent, your right to be treated at any GPDA location will be terminated and you will not be allowed to return for future treatment.**

Signature ______________________ Date ______________