

WELCOME

3769 Columbus Pike, Suite 100
Delaware, Ohio 43015

To Our Practice

Sachin S. Parulkar, D.D.S., L.L.C.

(740) 657-1562
www.delawarekidsdentist.com

Patient Registration and History

Patient Information

Date _____ ID/SS# _____ Birthdate ____ / ____ / ____

Name of Child _____
Last Name First Name MI

Gender ☐ M ☐ F Age _____ Nickname _____ Hobbies/Interests _____

Child's Home Address _____
Street City State Zip

Mailing Address (if different) _____
Street City State Zip

Name of School/Daycare _____ School Phone _____

Siblings (Names & Ages) _____

Person Financially Responsible _____ Home Phone (____) _____ Work Phone (____) _____

Whom may we thank for referring you? _____

Insurance

Mother's/Guardian's Name _____
Last First MI

☐ Mother ☐ Step Mother ☐ Guardian

Address (if different from patient's) _____

Home Phone(____) _____ Work Phone(____) _____

Cell Phone (____) _____ Email _____

Soc. Sec. # _____ Birthdate _____

Employer _____

Employer's address _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No

Father/Guardian's name _____
Last First MI

☐ Father ☐ Step Father ☐ Guardian

Address (if different from patient's) _____

Home Phone(____) _____ Work Phone(____) _____

Cell Phone(____) _____ Email _____

Soc. Sec. # _____ Birthdate _____

Employer _____

Employer's address _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Child's Medical Assistance I.D. # _____



Patient Name _____

Patient Date of Birth _____

Dental History

Date of last visit to a dentist _____

For what service? _____

	YES	NO
Has your child complained about dental problems?	☐	☐

	YES	NO
Is fluoride taken in any form (including water supply)?	☐	☐

Does your child brush teeth daily?	☐	☐
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Any injuries to mouth, teeth, head?	☐	☐
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Does your child use floss every day?	☐	☐
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Any unhappy dental experiences?	☐	☐
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Does your child grind his/her teeth ?	☐	☐
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Is your child experiencing any dental pain?	☐	☐
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Any mouth habits – thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?	☐	☐
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Medical History

Minor/Child's Physician _____ City/State _____ Phone (____) _____

Date of last physical examination _____ Results _____

	YES	NO
Is Minor/Child under care of physician now?	☐	☐

List all medications child currently taking _____

Receiving any medication or drugs?	☐	☐
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Is there excessive bleeding when cut?	☐	☐
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Latex Allergy?	☐	☐
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List all allergies _____

Any hospital stays or surgeries? If so please explain _____

Has Minor/Child had any history of or difficulty with any of the following? If yes, please check (✓)

☐ A.I.D.S./H.I.V.	☐ Behavioral issues	☐ Convulsions	☐ Heart problems	☐ Measles	☐ Sinus problems
☐ ADD/ADHD	☐ Blood disorders	☐ Diabetes	☐ Hemophilia	☐ Mononucleosis	☐ Skin rash/hives
☐ Anaphylaxis	☐ Blood transfusions	☐ Drug/alcohol abuse	☐ High blood pressure	☐ Mumps	☐ Tonsillitis
☐ Anemia	☐ Cancer	☐ Epilepsy	☐ Kidney problems	☐ Neurological problems	☐ Tuberculosis
☐ Asthma	☐ Chicken pox	☐ Fainting	☐ Leukemia	☐ Rheumatic Fever	☐ Other
☐ Autism	☐ Cleft lip/palate	☐ Hearing impairment	☐ Liver disease	☐ Sickle Cell Disease/Trait	_____

Emergency Contact

In the event of an emergency, whom should we contact? (other than parent/guardian)

Name _____ Relationship _____ Phone number(s) _____

Name _____ Relationship _____ Phone number(s) _____

Minor/child consent: I am the parent, guardian, or personal representative of _____ and there are no

Please Print Name of Child/Minor

court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including, but not limited to, x-rays and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

I certify that I am covered by insurance with _____ and assign directly to Dr. Sachin S. Parulkar all

Name of Insurance Company (if applicable)

insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I hereby authorize Dr. Parulkar to release all information necessary to secure the payment of benefits.

To the best of my knowledge, I certify that the above information is complete and correct. I understand that it is my responsibility to inform this office of any changes in my child's medical status or any other information provided in this form.

Signature of Parent, Guardian or Personal Representative

Date

Please Print Name of Parent, Guardian or Personal Representative

Relationship to Patient

