WELCOME

To Our Practice

3769 Columbus Pike, Suite 100
Delaware, Ohio 43015

(740) 657-1562
www.delawarekidsdentist.com

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

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. # _____

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Patient Name _____ Patient Date of Birth _____

Dental History

Date of last visit to a dentist _____ For what service? _____

	YES	NO		YES	NO
Has your child complained about dental problems?	☐	☐	Is fluoride taken in any form (including water supply)?	☐	☐
Does your child brush teeth daily?	☐	☐	Any injuries to mouth, teeth, head?	☐	☐
Does your child use floss every day?	☐	☐	Any unhappy dental experiences?	☐	☐
Does your child grind his/her teeth ?	☐	☐	Is your child experiencing any dental pain?	☐	☐
Any mouth habits – thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc?				☐	☐

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?	☐	☐	_____
Is there excessive bleeding when cut?	☐	☐	
Latex Allergy?	☐	☐	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

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Practice Financial Policy

We are committed to providing your child with the best possible care and are pleased to discuss our professional fees with you at any time. Your clear understanding of our financial and insurance policies is important to our professional relationship.

- All patients must complete and sign the Patient Registration and History form before seeing the Doctor.
- Full payment is due at the time of the service unless other arrangements are made ahead of time.
- Twenty-four business hours notice is required when re-scheduling or canceling appointments. **A cancellation fee of $25.00 will be assessed for broken appointments with less than 24 business hours notice.** After two broken appointments, our office reserves the right to schedule future appointments through our short call list only.
- For your convenience, we accept Cash, Personal Checks, ATM Debit Payments, Visa, Master Card, Discover, and Care Credit.
- For your convenience, we do accept most insurance carriers and would be more than happy to provide a treatment estimate for dental treatment. However, as the insured, it is also your responsibility to be aware of the provisions and benefits in your policy. Coverage may be different than estimated if your insurance deductible has not been met, annual maximum has been reached, if your insurance is paid out of network, if your coverage table is lower than average, or if your insurance carrier downgrades procedure materials. **As the insured, you are responsible for any charges not covered by your insurance carrier.**
- A $25.00 service fee will be assessed to any cancelled or returned checks.
- You understand that if you begin major treatment that involves lab work, you will be responsible for the fee at that time.
- If sent to collections, you understand that it is your full financial responsibility to pay all court costs and all collection fees and/or attorneys fees.
- Treatment plans may change, and you will be responsible for the work actually done.
- In accordance to Ohio law 3701.741, we reserve the right to charge $2.74 for the first ten pages of requested medical records, and $0.57/per page for pages eleven thru fifty when requested by the patient or patient's representative. Records requested by any other parties are subject to a $16.84 initial fee, as well as $1.11 for the first ten pages, and $0.57/per page for pages eleven thru fifty. In regards to digital x-rays, charges are $1.87 per page.
- For your convenience, this office may release your information to your insurance company, and receive payment directly from them. Every effort will be made to help you with your insurance, however, the insurance company, not our office, determines the dental benefits that you will receive. The estimated insurance coverage is not a guarantee of payment and is between you and the insurance company. All charges are your responsibility. Please keep your insurance information current by notifying us of any changes in employment and insurance coverage.

_____ _____

Name of Patient Patient's date of birth

_____ _____

Signature of Parent, Guardian or Personal Representative Date

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Acknowledgement of Receipt of Notice of Privacy Practices*

You may refuse to sign this Acknowledgement

I _____, have received a copy of this office's Notice of Privacy
(Please Print Your Name)

Practices and have been provided an opportunity to review it.

_____ _____
Name of Patient Patient's date of birth

_____ _____
Signature of Parent, Guardian or Personal Representative Date

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For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please specify) _____

*A copy of this office's Notice of Privacy Practices is provided for you at the reception desk.

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Authorization to Seek Medical/Dental Care

Patient(s) Name(s): _____

_____

I authorize Delaware Pediatric Dentistry – Sachin S. Parulkar, D.D.S., L.L.C. and personnel to treat my child _____ in my absence when the child is brought into the office by my designee(s).

The following person(s) named below are authorized to schedule appointments and seek dental care and treatment for the above names patient(s) with the doctors and staff of Delaware Pediatric Dentistry. Please be advised the individuals named below are people who will have access and knowledge of private health information:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I, _____, parent/legal guardian of the above named patient(s) give permission for the above named authorized individual(s) to seek medical/dental care in my absence.

_____
Parent/Legal guardian Printed Name

_____
Parent/Legal guardian Signed Name

_____
Date