

# 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?	<input type="checkbox"/>	<input type="checkbox"/>

	YES	NO
Is fluoride taken in any form (including water supply)?	<input type="checkbox"/>	<input type="checkbox"/>

Does your child brush teeth daily?	<input type="checkbox"/>	<input type="checkbox"/>
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Any injuries to mouth, teeth, head?	<input type="checkbox"/>	<input type="checkbox"/>
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Does your child use floss every day?	<input type="checkbox"/>	<input type="checkbox"/>
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Any unhappy dental experiences?	<input type="checkbox"/>	<input type="checkbox"/>
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Does your child grind his/her teeth ?	<input type="checkbox"/>	<input type="checkbox"/>
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Is your child experiencing any dental pain?	<input type="checkbox"/>	<input type="checkbox"/>
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Any mouth habits – thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? .....	<input type="checkbox"/>	<input type="checkbox"/>
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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?	<input type="checkbox"/>	<input type="checkbox"/>

List all medications child currently taking \_\_\_\_\_

Receiving any medication or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
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\_\_\_\_\_

Is there excessive bleeding when cut?	<input type="checkbox"/>	<input type="checkbox"/>
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Latex Allergy?	<input type="checkbox"/>	<input type="checkbox"/>
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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 (✓)

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

## **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.

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Name of Patient

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Patient's date of birth

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Signature of Parent, Guardian or Personal Representative

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Date



**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***

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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.