WELCOME

To Our Practice

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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 # _____

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 # _____

Is your child eligible for treatment under Medical Assistance? ☐ Yes ☐ No Child's Medical Assistance I.D. # _____

Delaware
PEDIATRIC DENTISTRY

Patient Name _____ Date _____

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 currently taking _____
Receiving any medication or drugs?	☐	☐	_____
Is there excessive bleeding when cut?	☐	☐	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?

Name _____ Relationship _____ Phone number(s) _____

Name _____ Relationship _____ Phone number(s) _____

To the best of my knowledge, 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.

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

_____ _____
Signature of Parent, Guardian or Personal Representative Date

_____ _____
Please print name of Parent, Guardian or Personal Representative Relationship to Patient

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