Diane C. Sizgorich, D.D.S.
Pediatric Dentistry
1411 West 7th Street, Suite C San Pedro, CA 90732 Phone: (310) 831-8861 Fax: (310) 831-0010 www.SanPedroPediatricDentist.com

Patient Introduction and History

Please assist us by answering the following questions which are important in evaluating and treating your child.

Child's Name _____ Nickname_____

Age _____ Date of Birth _____ Sex M / F School _____

Reason for today's visit _____

How did you hear about our office? _____

Medical History

Child's Physician_____ City_____ Phone _____

Last Physician Visit _____ Seen for _____

Is your child presently under care for any medical problems or conditions..... YES NO

Is your child currently taking any drugs or medications..... YES NO

If yes what? _____ Dose _____

Has your child has a history of any of the following.....

- ☐ Congenital heart disease, bleeding problems, anemia, or sickle cell disease
- ☐ Seizure disorders, epilepsy, convulsions, cerebral palsy, or brain injury
- ☐ Sight or hearing disorders or limitations
- ☐ Asthma, pneumonia, tuberculosis, cystic fibrous, or breathing difficulties
- ☐ Snoring, sleep apnea, or tonsillitis
- ☐ Stomach, intestinal, kidney, or liver problems including jaundice or hepatitis
- ☐ Diabetes, thyroid disorder, or other glandular problems
- ☐ Immune system disorders, including HIV or AIDS
- ☐ Cancer, tumors, or growths
- ☐ Joint or limb problems, including arthritis, or problems or weakness
- ☐ Surgeries (please specify) _____
- ☐ Allergies to any medications, foods or to latex rubber (please specify)_____
- ☐ My child has NO known medical problems

Are there any other medical problems or conditions you feel should be brought to the doctor's attention?

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Growth and Development

Was your child premature or low birth weight? Yes No

Did nursing, bottle feeding, or bottle habits continue beyond 18 months of age? Yes No

Does or did your child have any oral habits? Yes No
Circle all that apply… Thumb Finger(s) Blanket Pacifier Other
Discontinued at age_____

Does your child have learning disabilities, developmental delay or intellectual impairment? Yes No

Does your child have behavioral problems, attention disorder, or communication problems Yes No

Has your child received behavioral, psychological, or psychiatric evaluation, counseling or treatment? Yes No

Dental History

Is this your child's first dental visit? Yes No
Previous dentist _____ City_____ Date of Last Visit_____

Has your child had an unfavorable experience in a dental office? Yes No

Are you aware of any current dental problems which you expect will require treatment? Yes No

Has your child ever had a toothache or mouth pain? Yes No

Has your child experienced injuries to the mouth, teeth, or jaws? Yes No

Do you have any concerns regarding tooth grinding? Yes No

Does your child brush daily? Yes No

Is dental floss used daily? Yes No

Does an adult assist with brushing and flossing? Yes No

Has either parent has a lot of tooth decay or congenitally missing teeth? Yes No

Has either parent has a difficult time getting numb for dental work? Yes No

Consent for Dental Treatment

I request and authorize Dr. Sizgorich and her staff to examine, clean, and provide my child with comprehensive dental treatment including fillings, crowns, extractions, and nitrous oxide, if required. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Sizgorich to diagnose and/or treat my child's dental condition. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment age appropriate terms. Dr. Sizgorich will provide a setting likely to help children learn to cooperate during treatment including praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I understand that I will be responsible for any charges incurred on this child for dental treatment.

Signature: _____ Date: _____

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Family Record and Financial Responsibility

Date: _____

Name(s) and age(s) of children to be seen on your initial visit:

_____

Please list the names and ages of any additional brothers and sisters:

_____

Have any family members been patients in our office in the past? If so, please list:

_____

Residence address_____ City_____ Zip_____
Residence phone: _____ Cell _____ Email _____
Father's Name: _____ Marital Status: Married, Divorced,Single,Step-parent
Address if different_____ Phone: _____
Occupation _____ Employer_____
Business address_____City_____ Phone_____
Mother's Name: _____ Marital Status: Married, Divorced, Single, Step-parent
Address if different_____ Phone: _____
Occupation _____ Employer_____
Business address_____City_____ Phone_____
Who has legal custody of the patient? _____
If family is not living together, person financially responsible for this account_____

Dental Insurance Information

First Policy
Name of Person Insured_____ Relation to child_____
Social Security #_____ or Insurance ID #_____Birthdate_____
Ins. Co._____Group Name_____ Group/Policy #_____
Second Policy
Name of Person Insured_____ Relation to child_____
Social Security #_____ or Insurance ID #_____Birthdate_____
Ins. Co._____Group Name_____ Group/Policy #_____

Assignment of Benefits

I hereby authorize payment of insurance benefits otherwise payable to me directly to Dr. Diane C. Sizgorich. I understand that I am financially responsible for all charges not reimbursed by my insurance carriers. I authorize and consent to the release of dental and financial information necessary for the filing of insurance claims.

Signature_____ Date_____

Financial Responsibility

The information I have given is, to the best of my knowledge, accurate and complete. I understand that I am responsible for, and agree to the payment of all chargers incurred in the office in the care and treatment of my family members. In the event that financial responsibility changes, I understand that I am still responsible until new financial responsibility is established and accepted by Dr.Sizgorich. This acceptance of financial responsibility is to remain in force until canceled in writing.

Signature_____ Date_____

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FINANCIAL POLICY

Please be aware that the parent bringing the child to our office is responsible for payment of all charges. We cannot send statements to other persons. We ask that you pay the cost of the initial examination and any necessary dental x-rays on the day of that appointment. Please understand that financial arrangements are made directly with you.

For the convenience of our patients, the following alternatives are listed as a guide for possible financial arrangements.

1. **Payment is due in full** for each appointment as services are rendered. We accept cash, personal checks,
   Mastercard, Visa, and Discover. All checks will be verified using Tele-Check system and a bank fee will assessed on checks returned for any reason.
2. **Dental Insurance:** We are dedicated to providing all our patients with the *finest treatment available* and base our treatment recommendations on what will be best for your child and not what your insurance company does or does not pay. Please read the following in regards to your dental insurance coverage:
   - We must emphasize that as health care provider, our relationship is with you and not your dental insurance company. You dental insurance is a contract between your employer and the insurance company. Most plans routinely pay between 50-75%of the average total fee for a covered treatment.
     This percentage is determined by how much your employer has paid for coverage.
   - As a courtesy, we will be happy to file your insurance benefits. Any amount determined not to be a covered by your insurance company is payable at the time services are rendered; these fees may include deductibles, co-payments, certain, procedures not covered by your insurance policy, and the difference between our fees and the amount covered by your insurance company.
   - In the event your insurance carrier will not reimburse our office you will be responsible for the full cost of the visits at the time services are rendered and your insurance company will send you the reimbursement check directly.
   - We allow a maximum of 45 days for your insurance company to clear account balances. Any unpaid portions will be due in full, by you, after this period.
3. **Pre-Treatment Authorization:** Some insurance companies recommend an estimate of the work to be done and the fees to be charged before determining their benefits to you. If so, we will provide you with the pre-treatment fee estimate. In this case, it will be up to you to determine if you wish to proceed with the treatment before the insurance benefit is determined.
4. **White (Composite Resin) Filling.** Please be aware that your insurance company may not pay at the same level as a silver (amalgam) filling. In some cases. Dr. Diane Sizgorich may recommend placing a silver crown instead of a resin filling.
5. **Nitrous Oxide (Laughing Gas):** Nitrous Oxide is usually not covered by dental insurance. We thank you for your payment on the date of services.
6. **Emergency Treatment:** All emergency treatment must be paid in full at the time the service is rendered.

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FINANCIAL POLICY

7. **Past Due Accounts:** If your account becomes past due, we will take necessary steps to collect this debt. An interest fee of 18% will be charged for all debts past 60 days past due. If we have to refer your account to a collections agency, you agree to pay all our incurred collections costs.
8. If we have to refer collections of the balance to a lawyer, you agree to pay all our incurred lawyer fees plus all court costs. In case of a suit, you agree the venue shall be in Los Angeles, California.

Please remember even if you have insurance coverage, you are responsible for payment of your account. Please realize that your insurance coverage is a relationship between you, the insured patient, and your insurance company. Your understanding and cooperation with this matter is greatly appreciated. You are helping us keep our overhead expenses, in the form of direct and labor costs down. In addition, you are helping keep fees as low as possible.

I have read and understand my obligation.

Signature: _____ *Date:*_____