David L. Purczinsky, D.D.S.
Pediatric & Adolescent Dentistry

Date: _____

Patient Information

We welcome your child into our practice and we will try to make his/her her dental experiences very pleasant. Please complete this form thoroughly because this information is of great value in helping us to better understand and care for your child.

Patient Name: _____ Nickname: _____
Last First M.I.

❑ Male ❑ Female Siblings: _____ Weight: _____

Social Security #: _____ Birth Date: _____/_____/_____ Age: _____

Phone (Home): _____ Pediatrician: _____ Phone #: _____

Address (Home): _____
Street Apartment #

_____
City State Zip Code

Whom may we thank for referring you to our practice? _____

Health Information

Has your child ever had any of the following? Please check those that apply:

❑ AIDS	❑ Chicken Pox	❑ Liver Problems	❑ Thyroid Disorder
❑ Allergies (Environmental)	❑ Diabetes	❑ Lung Problems	❑ Tuberculosis
❑ Anemia	❑ Emotional Disorder	❑ Mental Retardation	❑ Vision Problems
❑ Asthma	❑ Epilepsy/Seizures	❑ Mumps/Measles	❑ Other
❑ Behavioral Problems	❑ Hearing Problems	❑ Pregnancy	_____
❑ Bleeding Disorder	❑ Heart Condition	❑ Respiratory Problems	_____
❑ Blood Transfusion	❑ Hepatitis	❑ Rheumatic Fever	_____
❑ Cancer	❑ Hospitalization	❑ Sinus Problems	_____
❑ Cerebral Palsy	❑ Kidney Problems	❑ Speech Problems	_____

Does your child have any drug allergies? _____

Is your child receiving any medications now? _____

Has your child been seen by another dentist? Date: _____ Location: _____

Has your child had an unfavorable dental experience? _____

Does your child have a toothache? _____ How frequent? _____

Does your child have a past history of: Thumb or finger sucking: _____ Pacifier: _____

Was your child breast-fed? _____ Bottle-fed? _____ Age discontinued: _____

What is your water source? Public system: _____ Private well: _____

How would you rate your own anxiety (fear, nervousness) at this moment? ❑ High ❑ Medium ❑ Low

How do you expect your child to react in the dental chair? ❑ Good ❑ Medium ❑ Poor

Do you desire complete, thorough dental care for your child? ❑ Yes ❑ No

Date: _____

Parent Information

Father's Name: _____ ❑ Married ❑ Single

Social Security #: _____ Birth Date: _____/_____/_____

TX Driver's License #: _____

Phone (Home): _____ (Work): _____ Ext:_____

Address (Home): _____
Street Apartment #

_____
City State Zip Code

Employer Name: _____ Occupation: _____

Mother's Name: _____ ❑ Married ❑ Single

Social Security #: _____ Birth Date: _____/_____/_____

TX Driver's License #: _____

Phone (Home): _____ (Work): _____ Ext:_____

Address (Home): _____
Street Apartment #

_____
City State Zip Code

Employer Name: _____ Occupation: _____

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? ❑ Yes ❑ No Insured's Birth Date: _____/_____/_____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Patient's relationship to insure: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

Employer Name: _____ Occupation: _____

Insurance Plan Name and Address: _____

ID #:_____ Group #:_____

I hereby authorize payment of the dental benefits otherwise payable to me, directly to Dr. David Purczinsky.

Signed (Employee/Subscriber) _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without previous financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charge will be paid by an insurance company.

I understand that the fee estimate listed for this dental care can only be extended for a period of six months from the date of the patient examination.

The undersigned herby authorizes Dr. Purczinsky to perform the examination, and after explanation, all forms of treatment, medication, and therapy indicated for the dental care of the above named child. This consent shall remain in full force and effect until cancelled by either party. Furthermore, the undersigned agrees to be responsible for any bill incurred on this child for dental treatment should named responsible party fail or insurance benefit be denied.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I have read the above conditions of treatment and agree to their content.

_____ Date: _____/_____/_____ Relationship to Patient _____
Signature of parent or guardian