Marius M. Laniauskas, D.D.S.
Landerbrook Dental Professionals • 5825 Landerbrook Drive, Suite 222, Mayfield Heights, OH 44124 • 216-752-8888

CHILD HEALTH HISTORY

Child's Name ______________________ ________________ ____________ **Age** _____ **Birth Date** ____/____/______
Last First Middle

Child's Nickname ______________________________________

Home Address ____ (____) ______________
Number Street City State Zip Code Telephone

Father's Name ____________________ ____________ **Mother's Name** ____________________ ____________
Last First Last First

Whom may we thank for referring you to our office? ______________________________________

DENTAL INSURANCE INFORMATION

Name of Dental Insurance Plan ____________________________ **Group Number** ____________________

Employee ______________________________ **Employee's Social Security No.** ____________________

Employee's Birth Date ____________________ **Patient's Relationship to Employee** __________________

Please encircle YES or NO. If YES, please fill in the details.

Yes No Is this your first visit to the dentist? If no, name of previous dentist ____________________

Yes No Is child under the care of a physician now? For what? ______________________________

Name of physician ____________________________________ Phone number __________________

Yes No Is child taking any prescription and/or over the counter medications or vitamin supplements?

Taking ______________ For ________________ Taking ______________ For ________________

Yes No Does child participate in active sports? ______________________________________

Is there now, or has there ever been any of the following:

Cavities ___ Toothache ___ Pain ___ Broken Tooth ___ Extracted teeth ___ Straightened teeth ___ Gum infection ___

What type of water does child drink? City ____ Well ____ Bottled ____ Filtered ____

What is the present dental problem? ____

Child's interests and hobbies ____

Has child had any history of the following? Please indicate with a Y (Yes) or N (No).

____ Any heart problems
____ Circulatory problems
____ Heart murmur
____ Artificial valve
____ Excessive bleeding

____ Anemia
____ Arthritis
____ Asthma
____ Cancer

____ Diabetes
____ Emotional Problems
____ Epilepsy
____ Fainting
____ Hearing Problems
____ Hepatitis
____ HIV (Aids Virus)
____ Joint Replacement
____ Kidney Disease
____ Mental Problems

____ Mumps
____ Pregnancy (Teens)
____ Rheumatic Fever
____ Scarlet Fever
____ Sickle Cell
____ Sinus Problems
____ Speech Problems
____ Thyroid Problems
____ Tuberculosis
____ Other ______________

____ Allergies to anesthetics
____ Allergies to medicines or drugs
____ Allergy to latex
____ Allergies to ________
____
____
____
____

Medical History Updated

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

PLEASE TURN THE PAGE

STATEMENT OF PATIENT FINANCIAL RESPONSIBILITY

Patient Name: ____

Drs. Miller/Laniauskas appreciate the confidence you have shown in choosing us to provide for your dental care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees.

As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. You will be responsible for your balance in full.

I understand that the responsibility for payment for professional services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless written financial arrangements have been made and signed by me. I understand that I will be responsible for any charges incurred by NOT providing the most current, correct insurance information to Drs. Miller/Laniauskas. In the event of default, I promise to pay interest on the indebtedness, together with any collection costs and attorney fees as may be required to effect collection, as well as pay any fees associated with returned checks.

I have read the above policy regarding my financial responsibility to Drs. Miller/Laniauskas, for providing dental services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Drs. Miller/Laniauskas.

Patient /
Legal Guardian Signature ____________________________________ **Date** _____________________

AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Drs. Miller/Laniauskas to release dental information acquired in the course of my examination or treatment, to my insurance company, or other physicians required to participate in my care.

Patient /
Legal Guardian Signature ____________________________________ **Date** _____________________

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY POLICY

I acknowledge that I have received a copy of Drs. Miller/Laniauskas Privacy Policy.

Patient /
Legal Guardian Signature ____________________________________ **Date** _____________________

CANCELLATION / NO SHOW POLICY

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call, if possible, 48 hours prior to your appointment.

I understand that I may be charged a service charge for a no show. I also understand that a no show for three appointments or cancellations of a total of four consecutive appointments, may result in a discharge from further dental care.

Patient /
Legal Guardian Signature ____________________________________ **Date** _____________________