**Marius M. Laniauskas, D.D.S.** ▪ **Thomas J. Drockton, D.D.S.** ▪ **Richard A. Miller, 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. Laniauskas/Drockton 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. Laniauskas/Drockton. 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. Laniauskas/Drockton, 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. Laniauskas/Drockton.

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

## AUTHORIZATION TO RELEASE INFORMATION

I hereby authorize Drs. Laniauskas/Drockton 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. Laniauskas/Drockton 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** _____________________