Stephen P Girdlestone DDS

PEDIATRIC DENTAL SPECIALIST

infants children teenagers

Pediatric Dental Specialist – Dr. Stephen Girdlestone

Who may we thank for referring you? -_____

Patient information: **Date:_____**

Child's name _____ Initial __ Last Name _____
Nickname _____ Birth date _____ Age ___ M / F
S.S. #_____
Address where child resides _____
_____
Has your child ever been seen by a dentist? ___ Yes ___ No
If yes, Dentist name_____ Last Visit date_____
Were X-rays taken? ____ Yes ____No
If no, would you like just an exam or exam and cleaning today? _____

Mother and / or Guardian's information:
First, Middle initial & last name

Name _____ Married – Single – Divorced – Separated – Widowed (Circle One)
Address _____
_____
Home phone _____ Work number _____ Cell _____
Other phone number (Grandparents / neighbor) _____
SS# _____ Employer _____
Birth Date: _____

Father's information: First, Middle initial & last name

Name: _____ Married – Single – Divorced – Separated – Widowed (Circle One)
Address if different than mothers _____
_____
Home phone _____ Work number _____ Cell _____
Other phone number (Grandparents / neighbor) _____
SS # _____ Employer _____
Birth Date: _____

Dental Insurance information:
Primary INS holder: Mother or Father Ins Co Name _____
Insurance Co. Name _____
Address _____
_____
Phone number _____
ID number as it shows on card _____
Group Number _____

We do not submit secondary insurance forms. We will be glad to provide you with the paperwork needed to file from home. Be sure and save the EOB's that you receive from your primary insurance company.

Signature _____

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Stephen P. Girdlestone, DDS
3801 Whipple Avenue NW, Suite 4
Canton, Ohio 44718
330-491-7777

MEDICAL HISTORY

PATIENT NAME_____ Birth Date _____

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now?	Yes	No	If yes, please explain: _____
Have you ever been hospitalized or had a major operation?	Yes	No	If yes, please explain: _____
Have you ever had a serious head or neck injury?	Yes	No	If yes, please explain: _____
Are you taking any medications, pills, or drugs?	Yes	No	If yes, please explain: _____
Do you take, or have you taken, Phen-Fen or Redux?	Yes	No	
Are you on a special diet?	Yes	No	
Do you use tobacco?	Yes	No	
Do you use controlled substances?	Yes	No	
Do you need to pre-medicate?	Yes	No	If yes, please explain: _____

Women: Are you Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Other If yes, please explain:

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Renal Dialysis	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Rheumatic Fever	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Rheumatism	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Scarlet Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Shingles	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	Hives or Rash	Yes	No	Sickle Cell Disease	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hypoglycemia	Yes	No	Sinus Trouble	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Irregular Heartbeat	Yes	No	Spina Bifida	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Kidney Problems	Yes	No	Stomach/Intestinal Disease	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Leukemia	Yes	No	Stroke	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Liver Disease	Yes	No	Swelling of Limbs	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Low Blood Pressure	Yes	No	Thyroid Disease	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Lung Disease	Yes	No	Tonsillitis	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Mitral Valve Prolapse	Yes	No	Tuberculosis	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pace Maker	Yes	No	Radiation Treatments	Yes	No	Yellow Jaundice	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Recent Weight Loss	Yes	No			

Have you ever had any serious illness not listed above? Yes No If yes, please explain: _____

Comments: _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN_____ DATE _____

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FINANCIAL POLICY

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care in a caring and enjoyable atmosphere. ***It is our policy to make definite financial arrangements with you before any treatment starts.*** Below is an explanation of our payment procedures. If you have any questions, please do not hesitate to ask.

1. Payment is due at the time of services. We accept cash, checks, Visa and MasterCard.

2. There will be a failed appointment fee of $50 for scheduled appointments. Our conscious sedation failed appointment fee is $100 if you do not give us a two-day notice of being canceled. If by chance the conscious sedation appointment is not completed the full conscious sedation fee is expected to be paid.

3. The office will accept assignment for only the primary insurance coverage only.

4. **Please provide us with your current dental insurance card so we can confirm your identification number and their mailing address. Insurance companies are not all using social security numbers as identification.**

5. If the claim is not paid by your insurance carrier within sixty days, you will be responsible for the full balance and further insurance appeal becomes your responsibility.

6. If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and co-payments at the time of service. **You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule.** Your insurance benefits are a contract between you and your employer. The amount of coverage you will receive will depends on the quality of the plan purchased by your employer, not the fees of the doctor.

7. ***Please note our office does not accept Medicaid or Medicaid Managed Care (i.e. HMOs) and are not able to treat Medicaid recipients. If, after services have been rendered, it is discovered that a patient is covered by Ohio Medicaid or a Medicaid HMO, Ohio Medicaid and any Medicaid HMO, will not be billed for any Medicaid covered service and that patient will be responsible for the fee for those services***.

8. Dr. Girdlestone is considered an "**out of network**" dentist with all insurance companies except Delta Premier.

9. After 90 days, we will inform you of the delinquent account by letter and if no action is taken to clear the account, this office will be required to employ collection service to collect payment. The responsible party agrees to pay all reasonable, related collection fees.

10. There will be a $30.00 service charge for all returned checks.

11. The parent or guardian who brings the child for their initial visit is responsible for payment independent of what a divorce decree may state. Reimbursement must be made between the divorced parents. We will not intervene.

AUTHORIZATION I authorize Dr. Girdlestone & staff to release any information concerning my case to my insurance company. I have read & accept the above Financial Policy, understand it & agree to the terms set forth regarding payment.

Signature of Parent or Responsible Party _____

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Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I received a copy of Dr. Girdlestone's Notice of Privacy Practices.

Patient name _____

Guardian Signature _____

Date _____

I _____ give Permission for the following people to bring in my child/children and discuss treatment and finances.

	Name	Address	Relationship	Phone
1.				
2.				
3.				
4.				
5				

If you need to add anyone else to the list, please fax over the information prior to the appointment at (330) 491-8888. Thank you.