Smile.®

Family Dental Care Associates
J. Michael Fuchs, D.D.S., Inc

THANK YOU FOR YOUR CONFIDENCE IN OUR CARE.

CHILD PATIENT INFORMATION

NAME _____ DATE OF BIRTH_____ SOCIAL SECURITY #_____
ADDRESS _____ CITY _____ STATE _____ ZIP _____
HOME TEL # _____ WORK TEL # _____
REFERRAL SOURCE:
TV _____ RADIO _____ YELLOW PAGES _____ NEWSPAPER _____ INSURANCE PLAN _____ OTHER_____
EMPLOYER _____ OCCUPATION _____
NAME OF SPOUSE _____ SPOUSE EMPLOYER _____
SPOUSE OCCUPATION _____ WORK TEL # _____
IF YOUR METHOD OF PAYMENT IS BY CHECK OR CREDIT CARD PLEASE COMPLETE THE FOLLOWING:
DRIVERS LICENSE # _____ STATE_____ EXP. DATE _____
MAJOR CREDIT CARD: ❑ VISA ❑ MASTERCARD ❑ SEARS ❑ DISCOVER
CREDIT CARD NO. _____ EXPIRATION DATE _____
WHO MAY WE CONTACT IN CASE OF EMERGENCY?
NAME _____ EMERGENCY TEL. # _____

INSURANCE INFORMATION

DO YOU HAVE DENTAL INSURANCE COVERAGE? YES _____ NO _____

PRIMARY INSURANCE	SECONDARY INSURANCE
HOLDER _____	HOLDER _____
DATE OF BIRTH _____	DATE OF BIRTH _____
INS. CO. NAME _____	INS. CO. NAME _____
GROUP # _____ LOCAL #_____	GROUP # _____ LOCAL #_____
POLICY # _____	POLICY # _____
EMPLOYER _____	EMPLOYER _____
PHONE NO. _____	PHONE NO. _____

HEALTH HISTORY

HAVE THERE BEEN ANY PROBLEMS IN YOUR GENERAL HEALTH WITHIN THE PAST 5 YEARS? (YES / NO)
(SERIOUS ILLNESS, HOSPITALIZATION SURGERY)
DESCRIBE PROBLEM _____
DATE OF LAST MEDICAL CHECK UP _____ ARE YOU UNDER PHYSICIANS CARE NOW? (YES / NO)
IF SO, PLEASE INDICATE WHY? _____
WHAT TABLETS, PILLS, OR LIQUIDS DO YOU TAKE (THIS INCLUDES ASPIRIN, VITAMINS, OTC, ETC.?
_____

Mason Montgomery
12160 Montgomery Road
Cincinnati, Ohio 45249
513-697-4300

Eastgate Mall
4595 Eastgate Blvd.
Cincinnati, Ohio 45245
513-753-8700

Northgate Mall
9505 Colerain Avenue
Cincinnati, Ohio 45251
513-385-7750

Tri County Mall
300 East Kemper Road
Cincinnati, Ohio 45246
513-671-6161

Western Hills Plaza
6016 Glenway Avenue
Cincinnati. Ohio 45211
513-481-2600

Family Dental Care Associates
J. Michael Fuchs, D.D.S., Inc.

Place a check in the proper bracket if your child now has problems with any of the following:

Heart	( )	Epilepsy	( )	Heart Murmur	( )	Rheumatic Fever	( )
Kidney	( )	Diabetes	( )	Speech	( )	Tuberculosis	( )
Liver	( )	Asthma	( )	Seizures	( )	Cerebral Palsy	( )
Hay Fever	( )	Cleft Palate	( )	School	( )	Excessive bleeding when cut	( )

DENTAL HISTORY

	YES	NO
Is this your child's first visit to the dentist?	( )	( )
When was the last visit?	( )	(
Will your child be a cooperative dental patient?	( )	( )
If no, explain _____		
Does your child take fluoride or vitamins with fluoride?	( )	( )
Has your child inherited any family dental characteristics?	( )	( )

Please check in the proper bracket if your child has or had any of the following dental problems:

Cavities	( )	Teeth bumped	( )
Toothache	( )	Crooked teeth	( )
Teeth sensitive to sweets	( )	Color of teeth	( )
Teeth sensitive to hot or cold	( )		

Have there been any other dental problems? What? ..... ( ) ( )

Have there been any injuries to your child's teeth? ..... ( ) ( )

Does your child have any oral habits? Thumb sucking, lip biting, finger sucking ..... ( ) ( )

If your child was bottle fed, at what age did your child give it up completely? _____

Please check reason for visiting our office:

Decay	( )	Habit	( )	Orthodontics	( )
Checkup	( )	Behavior	( )		
Emergency	( )	Physical or mental handicap	( )		
Other	( )	_____			

****

PATIENT CONSENT AND UNDERSTANDING

****

Permission is hereby granted to the Dentist and Specialists of Family Dental Care Associates, J. Michael Fuchs DDS Inc. and their staff to do all such things as they deem necessary to diagnose, treat and care for my child's dental needs.

Permission is also given to Family Dental Care Associates, J. Michael Fuchs DDS Inc. and their staff to furnish any insurance company obligated to me, or any welfare or relief organization, or any political subdivision to which I have applied or may subsequently apply for aid, any and all information with respect to any illness or injury, medical history, consultation or treatment or copies of such with respect to me and my family.

If my child receive services which are to be filed to my insurance company for payment, I hereby authorize my insurance company to pay to Family Dental Care Associates, J. Michael Fuchs DDS Inc. the benefits which would otherwise be payable to me. I also understand that I am fully responsible for the payment of all of the services provided for my child irrespective of whether my insurance company covers the services provided.

I understand that it is the policy of Family Dental Care Associates, J. Michael Fuchs DDS Inc. not to allow the parents/guardian of a child to be present in the treatment room while the child is being treated. This policy has been established to insure the safety of all concerned and to maximize infection control.

I understand that all xrays taken and clinical records remain the property of Family Dental Care Associates, J. Michael Fuchs DDS Inc. If I find it necessary to obtain a copy of my child's xrays and/or clinical records there will be a charge for that service.

I understand that with dental services, as with any other treatment of the body, the results are not always expected, desired or successful and that no guarantees are or can be made as to the result of any dental treatment or series of treatments.

I have completed, read and understand both sides of this form and in signing below I indicate my agreement with same.

_____ _____ / _____ / _____
Signature of patient Date

_____ _____ / _____ / _____
If patient is a minor (under age 18) signature of the patient's legal guardian Date

_____
NAME OF PERSON FINANCIALLY RESPONSIBLE FOR THIS ACCOUNT