GOLDEN ONSITE DENTAL

## PATIENT INFORMATION

Child's Name_____Child's Birthday _____/_____/_____

Child's Social Security Number _____-_____-_____ ◯ Male ◯ Female Pediatrician Group_____

Parent/Guardian Name _____

Address _____CITY_____STATE_____ ZIP_____

Home Phone _____ Cell Phone _____ Email _____

Emergency Contact_____ Phone _____

## MEDICAID/CHIP INFORMATION

UPMC For You UPMC For Kids Gateway Aetna Betterhealth Amerihealth United Healthcare

Dental Insurance Company _____ * Member ID Number _____

(*Required)

### OTHER DENTAL INSURANCE

Insured _____ Relationship to Patient _____Parent D.O.B. _____/_____/_____

Parent Social Security # _____ Insurance Company _____

Member ID Number _____ Group Number _____

Insured Address_____ Employer _____

## I WISH TO PAY THE REDUCE FEE FOR TODAYS VISIT (MY CHILD HAS NO DENTAL INSURANCE)

◯ UNDER 12 $68.00 ◯ X-RAYS $16

◯ OVER 12 $74.00

## CHILD'S MEDICAL HISTORY

*** ◯ CHECK IF ANTIBIOTIC PREMED REQUIRED ***

Yes No HEART MURMUR
Yes No ADHD/ADD
Yes No PSYCHIATRIC:_____
Yes No HEART ISSUES :_____
Yes No AUTISM SPECTRUM DISORDER
Yes No ALLERGY TO FOOD DYES
Yes No ASTHMA
DATE OF LAST ASTHMA ATTACK:_____

Yes No BLEEDING PROBLEMS
Yes No DIABETES
Yes No KIDNEY DISEASE
Yes No ALLERGY TO IBUPROFEN
Yes No PREGNANCY
Yes No ALLERGY TO SULFA
Yes No ALLERGY TO LATEX
Yes No SEIZURES
DATE OF LAST SEIZURES:_____

Yes No CANCER
Yes No STROKE
Yes No LIVE DISEASE
Yes No TONSILS & ADENOIDS REMOVED
Yes No G6PD
Yes No ALLERGY TO PENICILLIN
Yes No ALLERGY TO ASPIRIN

OTHER _____

### ALLERGIES:

◯ NONE _____

_____

### MEDICATIONS/SUPPLEMENTS CURRENTLY TAKING:

◯ NONE _____

_____

CONSENT: I UNDERSTAND AND AUTHORIZE GOLDEN ONSITE DENTAL TO PROVIDE DENTAL SERVICES INCLUDING BUT NOT LIMITED TO EXAM VIA TELEDENTISTRY, PROPHYLAXIS, ORAL EXAM, FLUORIDE, RADIOGRAPHS, SEALANTS SILVER DIAMINE FLUORIDE, AND IF NECESSARY AND APPROPRIATE, LOCATE ANESTHESIA, FILLINGS, EXTRACTIONS, STAINLESS STEEL CROWNS, PULPOTOMIES /PULPECTOMIES AND BEHAVIOR MANAGEMENT TO THE ABOVE-NAMED CHILD FOR WHOM I AM THE CUSTODIAL PARENT OR LEGAL GUARDIAN. I UNDERSTAND THIS CONSENT IS VALID FOR THE FIRST VISIT AND THE 6 MONTH RECALL, I AUTHORIZE AND DIRECT THE PROVIDER TO BILL AND COLLECT PAYMENT FROM ANY MEDICARD, INSURANCE, OR OTHER PAYER, TREATMENT BY THE DENTIST MAY AFFECT FUTURE BENEFITS THAT YOUR CHILD MAY RECEIVE UNDER CHIP, MEDICAID OR OTHER INSURANCE UPON SIGNING I ACKNOWLEDGE THAT I HAVE RECEIVED A COPY OF GOLDEN ONSITE DENTAL PRIVACY POLICY.

PARENT/GUARDIAN SIGNATURE _____ DATE _____/_____/_____

PARENT/GUARDIAN NAME (PRINT) _____ OFFICE REVIEW: _____