Dr. John J. Dubos, DDS, Inc.
3425 Grant Avenue
Suite A
Grove City, OH 43123
Phone: (614) 875-6601
Fax: (614) 875-0838

WELCOME!

ABOUT YOUR CHILD:

Today's Date: ________________

Child's Name: ___________________________
Last First MI

Nickname: ______________________________

□ Male □ Female Birthdate: ___/___/___

SS# _____-_____-_____ Age: ______

Home Address: __________________________

____

Home # (___) ________ Cell # (___) _________

E-Mail Address: _________________________

School: _____________________ Grade: ______

Referred by: ____________________________

Other family seen here: __________________

____

Previous/Present Dentist: _________________

Last Visit Date: ________________________

PARENT/GUARDIAN INFORMATION:

Mother: □ Step Mother □ Guardian

Name: _________________________________

Home # (___) ________ Cell # (___) _________

Birthdate __/__/__ SS# _____-_____-_____

Employer: ______________________________

Work # (___) _________ Ext. ______

Father: □ Step Father □ Guardian

Name: _________________________________

Home # (___) ________ Cell # (___) _________

Birthdate __/__/__ SS# _____-_____-_____

Employer: ______________________________

Work # (___) _________ Ext. ______

Parent's Marital Status: □ Married □Single
□ Divorced □ Separated □ Widowed □ Partnered

ACCOUNT RESPONSIBILITY:

Person Responsible for Account: ____________

Relation: _______________________________

Billing Address: __________________________

____

INSURANCE COVERAGE:

Primary

Dental Coverage □ Yes □ No

Company Name: ___________________________

Company Address: _________________________

____

Company Phone: (___) ____________

Group # (Plan, Local or Policy #): ____________

Insured's Name: __________________________

Relation: __________ Insured's ID #: ________

Secondary

Dental Coverage □ Yes □ No

Company Name: ___________________________

Company Address: _________________________

____

Company Phone: (___) ____________

Group # (Plan, Local or Policy #): ____________

Insured's Name: __________________________

Relation: __________ Insured's ID #: ________

EMERGENCY CONTACT:

Please list a relative or neighbor not living with you

Name: _________________ Relation: __________

Home # (___) ________ Cell # (___) _________

Work # (___) _________ Ext. ______

MEDICAL HISTORY:

Child's Physician: ___________________________
Phone #: (___) _______ Last Visit: ___________
Are they currently under their care? □ Yes □ No
Please Explain: ___________________________
____
____
____
Their current physical health is: □ Good □ Fair □ Poor
Are they taking any prescription/over-the-counter or herbal supplement drugs: □ Yes □ No
Please list each one: ______________________
____
____
____
Have they ever taken Phen-fen? □ Yes □ No
(Also known as Redux or Pondimin)

Have they ever had any of the following diseases or medical problems?

Y N Abnormal Bleeding
Y N ADD/ADHD
Y N Allergies to any Drugs
Y N Any Hospital Stays
Y N Ay Operations
Y N Artificial Bones/Joints/Valves
Y N Asthma
Y N Cancer/Chemotherapy
Y N Congenital Heart Defect
Y N Convulsions/Epilepsy
Y N Diabetes
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV^+ or AIDS
Y N Kidney/Liver Problems
Y N Rheumatic/Scarlet Fever
Y N Sickle Cell Disease/Traits
Y N Tuberculosis (TB)

Please list any serious medical condition(s) that they have ever had: ______________________
____
____

Are they allergic to any of the following?

Y N Aspirin
Y N Codeine
Y N Dental Anesthetic
Y N Erythromycin
Y N Jewelry
Y N Latex
Y N Metals
Y N Penicillin
Y N Plastic
Y N Sulfa Drugs
Y N Tetracycline

Please list any other drugs/materials they are allergic to: _______________________________
____

DENTAL HISTORY:

Why did you bring the child to the dentist today?
____
____

Have they ever had a serious problem associated with previous dental work? □ Yes □ No
Is their water fluoridated? □ Yes □ No
Are they taking fluoride supplements?□ Yes □ No
Have they ever had any pain/tenderness in their jaw joint (TMJ/TMD)? □ Yes □ No
Do they brush their teeth daily? □ Yes □ No
Do they floss their teeth daily? □ Yes □ No

Do/did they have any of the following habits?
Y N Lip Sucking/Biting
Y N Nail Biting
Y N Nursing Bottle Habits
Y N Thumb/Finger Sucking

I understand that the information that I have given today is correct to the best of my knowledge. I also understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform any necessary dental services that they may need during diagnosis and treatment with my informed consent.

____
Parent/Guardian Signature Date

Payment is due in full at the time of treatment unless prior arrangements have been approved.

If this office accepts insurance I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductibles that my insurance may not cover.

____
Parent/Guardian Signature Date

Our office is HIPAA Compliant and committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.