Welcome

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventative care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime

LEGACY DENTAL

Mark Friedrich DDS, Nathan Bojrab DDS, Margaret Neese DDS • 7215 Engle Road, Fort Wayne, IN 46804 • 260-434-1133

1 Tell Us About Your Child

Today's Date: _____

Child's Name: _____
Last First MI

Child's Home Address: _____
Apt/Condo #

_____
City State Zip

Child's Home # _____

Child's Birthdate: _____ Child's Age: _____

Child's SS#: _____

Nickname: _____ ☐ Male ☐ Female

2 Who is Accompanying the Child Today?

Name: _____

Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Is the child adopted? ☐ Yes ☐ No

Is the child in a foster home? ☐ Yes ☐ No

Parent's Marital Status ☐ Single ☐ Widowed ☐ Married ☐ Divorced ☐ Separated

3 Person Responsible for Account

☐ Mother ☐ Step ☐ Guardian

☐ Father ☐ Step ☐ Guardian

Name: _____ Birthdate: _____

Billing Address: _____

_____

Hm Email: _____

Wk Email: _____

Wk #: _____ Ext. _____

Hm #: _____

Employer: _____

SS #: _____ DL #: _____

4 Whom May We Thank

Please check a referral source below.

❒ Google

❒ Social Media (Facebook, Twitter, Instagram) Please List:

_____

❒ Website

❒ TV/Radio, Newspaper, Magazine (Please List)

_____

❒ Community Event/Fair _____

❒ Family/Friend _____

❒ Other _____

5 Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS #: _____

Insured's Employer: _____

Insured's Address: _____

Secondary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone #: _____

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

Insured's Name: _____ Relation: _____

Insured's Birthdate: _____ Insured's SS #: _____

Insured's Employer: _____

Insured's Address: _____

In the event of an emergency, is there someone who lives near you that we should contact?

His/Her Name: _____ Relation: _____

Wk #: _____ Hm #: _____

Address: _____

_____

CONTINUED ON BACK

6 Medical Information

Child's Physician: _____

Phone #: _____ Date of last visit: _____

Is the child currently under the care of a physician? Yes No

Please describe the child's current physical health:

☐ Good ☐ Fair ☐ Poor

Please list all drugs that the child is currently taking:

_____

_____

Please list all drugs that the child is allergic to:

_____

_____

Does/did the child have any of the following habits?

Y N Lip Sucking/Biting

Y N Nursing Bottle Habits

Y N Nail Biting

Y N Thumb/Finger Sucking

Was the child breast fed? ☐ Yes ☐ No

7 Has the child ever had any of the following medical problems?

Y	N	Abdominal Bleeding	Y	N	Hearing Impairment
Y	N	Allergies to any Drugs	Y	N	Heart Murmur
Y	N	Anemia	Y	N	Hemophilia
Y	N	Any Hospital Stays	Y	N	Hepatitis
Y	N	Any Operations	Y	N	Hives
Y	N	Asthma	Y	N	HIV+/AIDS
Y	N	Cancer	Y	N	Immunizations Current
Y	N	Chicken Pox	Y	N	Kidney/Liver Problems
Y	N	Congenital Heart Defect	Y	N	Measles
Y	N	Convulsions/Epilepsy	Y	N	Mononucleosis
Y	N	Diabetes	Y	N	Rheumatic/Scarlet Fever
Y	N	Exposed to HIV, but Neg.	Y	N	Skin Rash
Y	N	Handicaps/Disabilities	Y	N	Tuberculosis (TB)

Anything you would like to discuss with Doctor in private?

☐ Yes ☐ No

Please discuss any serious medical problems that the child has had:

_____

_____

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 of confidence and it is my responsibility to inform this office of any changes in my medical status.

I understand that I am responsible for payment of services rendered and shall be responsible for any court costs and attorney fees if they are deemed ncessary for collection of debt. I further consent to jurisdiction for any litigation being granted in Allen County, Indiana.

_____ _____

Signature of Parent or Guardian Date

Payment is due in full at the time of treatment.

We want our patients to be able to comfortably afford dental care.
We will gladly discuss our financial policies with you before beginning your treatment.
We require 48 hours notice to change or cancel an appointment to avoid being charged for the appointment.

Thank you for filling out this form completely. It will enable us to help you more effectively.
If you have any questions at any time, please ask us. We are happy to help.

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