Welcome to the Pediatric Dental Practice of *Dr. Gregory Kuchtjak, DMD,PA*

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

CHILD'S Last Name **First** Nickname Child's SSN Today's Date

Birthdate_____ Age____ Sex____ Race_____ School_____ Grade_____

Childs Home Address_____

Lives with Both Parents / Mother / Father / Other_____

Brothers _____ Sisters_____ Pets_____

Child's Physician_____Last Seen_____ Pharmacy_____ Telephone_____

Responsible Party Information

Mother **Stepmother** **Guardian**

Name_____ Martial Status:Single, Married, Divorced, Widowed, Separated
Address(if different from above)_____
Home Phone_____Work Phone_____Cell Phone_____
Employer_____Occupation_____E-Mail Address_____

Father **Stepfather** **Guardian**

Name_____Martial Status:Single, Married, Divorced, Widowed, Separated
Address(if different from above)_____
Home Phone_____Work Phone_____Cell Phone_____
Employer_____Occupation_____E-Mail Address_____

Primary Dental Insurance
Insured's Name_____
Relationship_____
Birthdate_____ Soc Sec#_____
Employer_____
Ins Company_____
Ins Co Address_____
ID #_____Group #_____
Has your child received previous dental care under ths plan YES NO

Additional Insurance
Insured's Name_____
Relationship_____
Birthdate_____ Soc Sec#_____
Employer_____
Ins Company_____
Ins Co Address_____
ID #_____ Group #_____
Has your child received previous dental care under this plan YES NO

Reason for bringing child to dentist_____

Whom may we thank for referring you_____

Dental & Health History

Is your child being treated by a physician at this time? Y N
If yes why?_____
Has your child ever been a patient in a hospital? Y N
If yes, why?_____
Has your child ever received general anesthesia or sedation? Y N
If yes, why?_____
Is your child allergic to anything? (medicine, latex, food) Y N
If yes, why?_____
Is your child taking any medicines at this time? Y N
If yes, what?_____
Has your child ever had a blood transfusion? Y N
Has your child had difficulty with previous dental visits?
If yes, explain_____
Has your child ever received fluoride in any form? Y N
If yes, what?_____

Previous Dentist_____

Does your child brush his/her teeth daily? Y N
Do you assist child with tooth brushing? Y N
Is Dental Floss used? Y N
Does your child take any fluoride supplement Y N
Any mouth habits (finger/thumb sucking, chew nails or objects(pencils), grind teeth, nursing bottle habits, pacifier, etc_____ Y N
Any Injuries to mouth, teeth, head? Y N
If yes, when _____
Does your child smoke or use tobacco products Y N

Type of toothpaste child uses_____
Age child stopped bottle/breast feeding_____

Date of last dental visit_____

Date last x-rays made?_____

GREGORY J. KUCHTJAK, D.M.D.,P.A.
Pediatric dentistry

FINANCIAL AGREEMENT:
We would like to take the opportunity to thank you for choosing us as your child's dental care provider.

Payment for services is required at each appointment, unless prior financial arrangements have been made. Also be aware, the parent bringing the child to the office is responsible for payment, unless other arrangements have been made in advance.

We accept American Express, Care Credit, Cash, Debit Cards, Discover, Master Card and Visa. Outside financing for services over $1,000.00 is available through Care Credit.

Because insurance policies vary greatly, we can estimate your coverage in good faith, but cannot guarantee it. Not all services are a covered benefit in all contracts. There are more than 300 insurance companies and plans offer different degrees of coverage based on what your employer has chosen for you. As a service to our patients we will be happy to electronically file your primary insurance claim. Please allow up to 30 days to receive direct reimbursement from your Insurance company. You must provide us with an insurance card and all the information necessary to verify coverage. We can also assist in the completion of secondary insurance forms.

I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to Dr Gregory Kuchtjak.

_____

Signature of Parent or Guardian Date

OFFICE AGREEMENT:
We make every effort to be on time for our patients and ask that you extend the same courtesy to us. Once an appointment has been made, that time is reserved specifically for your child. Please call at least 48 business hours in advance in the event your child's appointment must be rescheduled or cancelled. Broken appointments prevent others from receiving the dental care they deserve, we take them seriously, so please be considerate and inform us in advance if you need to change your appointment. We realize unexpected things can happen, but we ask for your assistance in this regard. We reserve the right to charge a fee for all cancelled or missed appointments without 48 business hours notice. We reserve the right to terminate professional treatment of any patient when appointments are not kept.

AUTHORIZATION AND RELEASE
I authorize release of any information relating to my family's dental claims to my insurance company of record during the period of such dental care.

_____ _____

Signature of Parent or Guardian Date

933 CAROLINA AVE. NORTH STATESVILLE, NC 28677 PHONE (704)883-8516 FAX (704)883-8560

Organs and Systems

Has this child ever had any treatment for any of the following? Please circle Yes or No.

Blood / Circulatory	Y	N	Gastrointestional/Stomach	Y	N	Muscles	Y	N
Bones	Y	N	Kidney / Bladder	Y	N	Nervous System	Y	N
Endocrine Glands	Y	N	Heart	Y	N	Skin	Y	N
Eyes, Ears, Nose, Throat	Y	N	Heart Murmur	Y	N	Tonsils / Adenoids	Y	N
Respiratory / Lungs	Y	N	Liver	Y	N			

Illness

Has this child ever been diagnosed as havng any of the following conditions? Please circle Yes or No.

AIDS/HIV	Y	N	Eye Problems	Y	N	Pneumonia	Y	N
Anemia	Y	N	Excessive Bleeding	Y	N	Polio	Y	N
Allergy	Y	N	Fainting	Y	N	Psychiatric Disorder	Y	N
Arthritis	Y	N	Handicaps/Disabilities	Y	N	Rheumatic Fever	Y	N
Asthma	Y	N	Hearing Loss	Y	N	Scarlet Fever	Y	N
Autism	Y	N	Heart Disease	Y	N	Scoliosis	Y	N
Brain Injury	Y	N	Hemophilla	Y	N	Sickle Cell Anemia	Y	N
Bronchitis	Y	N	Hepatitis Type _____	Y	N	Sinus Problems	Y	N
Cancer	Y	N	Jaundice	Y	N	Snoring	Y	N
Cerebral Palsy	Y	N	Leukemia	Y	N	Sore Throats - Frequent	Y	N
Chicken Pox	Y	N	Measles	Y	N	Spina Bifida	Y	N
Cleft Lip / Palate	Y	N	Mental Retardation	Y	N	Syndrome_____	Y	N
Convulsions/Seizures	Y	N	Mumps	Y	N	Tetanus	Y	N
Diabetes	Y	N	Mouth Breathing	Y	N	Tuberculosis	Y	N
Diphtheria	Y	N	Nutritional Deficiency	Y	N	Veneral Disease	Y	N
Drug/Alcohol Abuse	Y	N	Orthopedic Problems	Y	N	Whooping Cough	Y	N
Epilepsy	Y	N	Pregnancy	Y	N	Other _____		

_____

Is there anything else that you think we should know about your child?

_____

_____

_____

I certify that I have read and understand the above questions and have, to the best of my knowledge, answered accurately. I will not hold Dr. Kuchtjak or any member of his staff responsible for any errors or omissions I may have made in completion of this form

_____ _____ _____

Signature of Person Completing Form | Relationship to Patient | Date

Dentist Review

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