Dr. William L. Kochenour and Associates

Orthodontic and Children's Dental Specialists

727-789-6347

Patient Information

Name _____ _____ Sex: M or F Age:____ Birthdate _____
First MI Last Nickname

Address _____ City _____ ST____ ZIP_____

Father's Information

Name _____
First MI Last

Address _____

City _____ ST ____ Zip _____

Home #: _____ Work #:_____

Cell #: _____

Email: _____

Would you like to receive appt. confirmation via:

Text Message: Yes or No Email: Yes or No

DOB: _____ Age ___ Sex: ___ Marital Status:_____

SS#: _____DL#:_____

Employer Information

Name _____

Address _____

City _____ ST ____ Zip _____

Dental Insurance Company

Name _____

Address _____

City _____ ST ____ Zip _____

Phone: _____

Group #: _____ Local or Union#:_____

Mother's Information

Name _____
First MI Last

Address _____

City _____ ST ____ Zip _____

Home #: _____ Work #:_____

Cell #: _____

Email: _____

Would you like to receive appt. confirmation via:

Text Message: Yes or No Email: Yes or No

DOB: _____ Age ___ Sex: ___ Marital Status:_____

SS#: _____DL#:_____

Employer Information

Name _____

Address _____

City _____ ST ____ Zip _____

Dental Insurance Company

Name _____

Address _____

City _____ ST ____ Zip _____

Phone: _____

Group #: _____ ID#_____

Medical History

Allergies	Yes	No
Latex Allergy	Yes	No
Asthma	Yes	No
Bleeding Problems	Yes	No
Blood Disorders	Yes	No
Brain Injury	Yes	No
Cancer	Yes	No
Cleft Lip/Palate	Yes	No
Diabetes	Yes	No
Emotional Problems	Yes	No
Eye Problems	Yes	No
Fainting	Yes	No
Hearing Loss	Yes	No
Heart Disease	Yes	No
Heart Murmur	Yes	No
Hepatitis	Yes	No
Jaundice	Yes	No
Nutritional Deficiency	Yes	No
Orthopedic Problems	Yes	No
Physical Limitations	Yes	No
Seizure Disorder	Yes	No
Spina bifida	Yes	No

Please list any current medications your child is taking:

_____

_____

Is your child presently undergoing medical treatment? Yes No

_____

Has your child ever been hospitalized? Yes No

Is your child up to date with immunizations? Yes No

_____

Have you been told that your child needs pre-medication prior to a dental cleaning? Yes No

Has your child ever had a blood transfusion? Yes No

If so, when? _____

Is there anything the doctor should know about your child?

_____

_____

_____

_____

Dental History

Habits		
Teeth GrindingYes	No	
Cheek Biting	Yes	No
Tongue Thrusting	Yes	No
Mouth Breather	Yes	No
Bulimia/Anorexia	Yes	No
Nail Biting	Yes	No
Thumb Sucking	Yes	No
Finger Sucking	Yes	No
Chewing Gum	Yes	No
Candy	Yes	No
Soft Drinks	Yes	No
Bottle Feeding or Nursing	Yes	No
Pacifier	Yes	No

Is this your child's first visit to the dentist? Yes No

If no, date of last exam _____

Date of last x-rays _____

Dentist's Name _____

How often does your child brush? _____

How often does your child floss? _____

Do you supervise your child's dental home care? Yes No

Toothpaste _____

Mouthwash _____

Does your child take a fluoride supplement? Yes No

If so, what? _____

Does your child swallow toothpaste? Yes No

Other Information

Physician Name:_____

Physician Phone#: _____

School Name: _____

Other Children _____ D.O.B. _____

Other Children _____ D.O.B. _____

Sports or Hobbies: _____

Whom may we thank for referring you? _____

I understand that where appropriate, credit bureau reports may be obtained:

SIGNATURE _____ Relationship to Patient _____DATE _____

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Financial Agreement

Payment in full is expected on the day of service by cash, check, Visa, MasterCard, or Discover. *The parent or legal guardian accompanying the child into the office for dental treatment is financially responsible regardless of dental insurance or legal responsibility.*

We will file dental insurance as a courtesy to our patients. Dental insurance policies are an arrangement between the insurance company and the insured member. If for any reason the insurance company does not cover dental procedures, the below signed Responsible Party agrees to pay any and all remaining balance. Insurance deductibles and co-payments will be due on date of service.

All accounts sixty days past due may be processed on to AWA collections. If an account is sent to collections, patients will no longer be seen in the practice.

As a courtesy to the office and so emergency patients can receive immediate care, we require a twenty-four hour notice of change or cancellation of your appointment.

By signing below, I understand and agree that in the event of default, I am legally liable for all costs of collection including collection fees, reasonable attorney fees, and court costs, and all other costs related to the collection of this debt.

Parent/Legal Guardian Name:

_____

Parent/Legal Guardian Signature:

_____

Date_____

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AUTHORIZATION FOR DENTAL TREATMENT

Patient's Name:_____

Health care providers are required by Florida State Law to inform patients regarding treatment or procedures, techniques, or treatment considered to be of concern to patient, parent or legal guardian.

I, being the parent or legal guardian of the above minor patient, hereby do authorize and request performance of dental services for this patient and the use of whatever procedures Dr. Dustin A. DeDomenico deem necessary during treatment. **If a child is under the age of eighteen, a parent, legal guardian or someone possessing a power of attorney must accompany them to dental appointments.**

I understand that Dr. Dustin A. DeDomenico and such assistants as she may designate to treat the above-mentioned patient, will use restorative, oral surgery, and patient management techniques that are reasonable, necessary and advisable.

I authorize the administration of anesthetics,analgesics or nitrous oxide, which may be deemed advisable by Dr. Dustin A. DeDomenico. The use of Nitrous oxide will be explained to me, including the benefits and temporary side effects, which may include but are not limited to tingling in fingers, toes, cheeks, tongue, head; nausea; heaviness in thighs and/or legs followed by a lighter floating feeling; warm feeling throughout body.

I consent that Dr. Dustin A. DeDomenico may use my dental radiographs or clinical photographs for the patient records.

I understand that the treatment plan to be presented, along with the fees outlined, could change depending upon the time elapsed since the initial examination and the extent of dental pathology.

I agree to diagnostic procedures and dental treatments as deemed necessary and desirable for the above named patient.

I understand that after considering risks, benefits, and treatment alternatives, I have the ability to give an informed consent, which indicates my awareness of sufficient information to make a personal choice regarding the treatment of my child.

I understand the possibility and nature of complications cannot be accurately predicted, therefore, there can be no guarantee as to the result of treatment.

Parent/Legal Guardian Name:_____

Parent/Legal Guardian Signature:_____

Date:_____