DONALD WONG, D.D.S.
1132 INDEPENDENCE AVENUE
MARION, OHIO 43302
(740) 383-3223

Tell Us About Your Child

Today's Date: ____________________________ Child's Home Phone #: (______) _________________ Child's Social Security #: ___________________________

Child's Name: ____ Child's Birthdate: ______/______/______ Child's Age: _____
First Last Middle

Name we should call your child: ______________________________________ ❑ Male ❑ Female School: _________________________________ Grade: _____

Child's Home Address: ____
Street City State Zip

Your Name: ____ Your Relationship to Patient: ___________________________

Who may we thank for referring you? ____

What is the primary reason for today's visit? ____

Dental History

Is your child currently in pain? ❑ Yes ❑ No Is this your child's first time seeing a dentist? ❑ Yes ❑ No

Have we seen anyone else in your family? ❑ Yes ❑ No List if yes ____

Has your child experienced problems with previous dental work? ❑ Yes ❑ No If yes, explain: ____

Previous Dentist: ____ Date of Last Visit: __________________ Date of Last X-Ray: __________________

Have there been any injuries to your child's teeth, jaws, falls, blows, chips, etc.? ❑ Yes ❑ No

Has your child been seen by an orthodontist? ❑ Yes ❑ No Orthodontist Name___________________________________

Does your child brush his/her teeth daily? ❑ Yes ❑ No Does he/she require parental help? ❑ Yes ❑ No

Does your child floss his/her teeth daily? ❑ Yes ❑ No Does he/she require parental help? ❑ Yes ❑ No

Medical History

Child's Physician: ____Phone: (______) _________________ Date of last visit: ______________________________

Address: ____

Is your child under the care of a physician? ❑ Yes ❑ No Please explain: ____

Does patient require antibiotic pre-medication prior to dental treatment? ❑ Yes ❑ No

Please list all medications and dosage that your child is currently taking: ____

Please list all drugs, antibiotics or things that cause your child allergic reactions:____

Anything you would like to discuss with the Doctor in Private? ❑ Yes ❑ No

Has your child had/experienced any of the following (please check)

Abnormal Bleeding	❑	**Chemotherapy**	❑	**Hepatitis**	❑	Seizures	❑		
AIDS/HIV	❑	Congenital Birth Defect	❑	High Blood Pressure	❑	Scarlet Fever	❑	Heart Problem	❑
Anemia	❑	Congenital Heart Defect	❑	Hives	❑	Sickle Cell Anemia	❑	Describe: __________________	
Artificial Heart Valve	❑	**Diabetes**	❑	**Kidney Problems**	❑	Skin Rash	❑	__________________________	
Artificial Joints	❑	Epilepsy	❑	**Liver/GI System Problems**	❑	Tonsillitis	❑		
Asthma	❑	**Fainting**	❑	**Radiation Treatment**	❑	Tuberculosis (TB)	❑		
Blood Disease	❑	**Fever**	❑	Recurrent/Frequent Headaches	❑	**Heart Murmur**	❑		
Cancer/Tumors	❑	**Hemophilia**	❑	Rheumatic Fever	❑	Mitral Valve Prolapse	❑	No Medical Issue	❑

Emergency Contact

Name: ____ Relationship to Patient: ___________________________

Address: ____
Street City State Zip

Phone #: (_______) _________________________ Work #: (_______) _________________________ Cell #: (_______) _________________________

❏ **MOTHER:** ❏ Step Mother ❏ Legal Guardian Birthdate: ____/____/____ Home Phone #: (_____) _______________ Work Phone #: (_____) ____________

Name: ____ Social Security #: ____________________ Cell Phone #: (_____) ____________

Address: ____
Street City State Zip

No. of yrs. at this Address: ________ Employer: ____ Length of Employment: _________

Parent's Marital Status: ❏ Married ❏ Divorced ❏ Separated ❏ Widowed ❏ Remarried ❏ Single

❏ **FATHER:** ❏ Step Father ❏ Legal Guardian Birthdate: ____/____/____ Home Phone #: (_____) ______________ Work Phone #: (_____) ____________

Name: ____ Social Security #: ____________________ Cell Phone #: (_____) ____________

Address: ____
Street City State Zip

No. of yrs. at this Address: ________ Employer: ____ Length of Employment: _________

Parent's Marital Status: ❏ Married ❏ Divorced ❏ Separated ❏ Widowed ❏ Remarried ❏ Single

PRIMARY INSURANCE

Primary Dental Ins. Co.: ______________________________ Phone #: (_____) _____________ Group # (Plan, Local, or Policy #): ____________________

Primary Dental Ins. Co. Address: ____
Street City State Zip

Policy Owner's Name: ____ Relationship to Patient: ___________________________

Policy Owner's Birthdate: ____/____/____ Social Security #: ________________________________ Occupation: _________________________________

Place of Employment: ____ Phone Number: _____________________________

SECONDARY INSURANCE

Secondary Dental Ins. Co.: _________________________ Phone #: (_____) ________________ Group # (Plan, Local, or Policy #): ____________________

Secondary Dental Ins. Co. Address: ____
Street City State Zip

Policy Owner's Name: ____ Relationship to Patient: ___________________________

Policy Owner's Birthdate: ____/____/____ Social Security #: _________________________________ Occupation: ________________________________

Place of Employment: ____ Phone Number: _____________________________

ACKNOWLEDGEMENT OF RESPONSIBLE PARTY

- The undersigned hereby represents that he/she is the parent and/or legal guardian of ____ and is a person authorized by law to consent to treatment of the above-named patient. In addition to the undersigned, the following is a list of other individuals that are entitled to give consent to treatment:

	NAME	RELATIONSHIP
A.	____	____________________
B.	____	____________________
C.	____	____________________

- The undersigned further acknowledges that he/she hereby accepts responsibility to pay for all treatment rendered to the above-named patient whether or not said treatment is covered by insurance. The undersigned shall be responsible to make payment on the previously agreed schedule regardless of whether insurance proceeds have been received. Unless arrangements are made in advance, payment is due when services are rendered.
- The undersigned acknowledges that account balances 60 days or older will be assessed a 1.5 % monthly finance charge.
- The undersigned acknowledges that there will be a charge for broken appointments. To avoid a charge please give a 24 hours notice if you need to change an appointment.
- The undersigned acknowledges that after two broken or missed appointment times, Dr. Donald Wong reserves that right to dismiss the patient from his practice.
- The undersigned hereby authorizes any insurance carrier to make payment directly to Dr. Donald Wong

____
Parent or Legal Guardian

AT THIS OFFICE WE FOLLOW THE GUIDELINES OF THE AMERICAN ACADEMY OF PEDIATRIC DENTISTRY IN REGARD TO FREQUENCY OF X-RAYS, CLEANINGS, FLUORIDE TREATMENTS AND RESTORATIVE CARE. WE CONSIDER THESE GUIDELINES TO BE THE STANDARD OF CARE (BEST TREATMENT FOR YOUR CHILD). THESE GUIDELINES ARE NOT DICTATED BY DENTAL INSURANCE AND IT IS YOUR RESPONSIBILITY TO UNDERSTAND WHETHER YOUR PARTICULAR INSURANCE PLAN WILL REIMBURSE YOU FOR THESE SERVICES. PLEASE CALL YOUR INSURANCE COMPANY WITH QUESTIONS REGARDING FREQUENCIES.