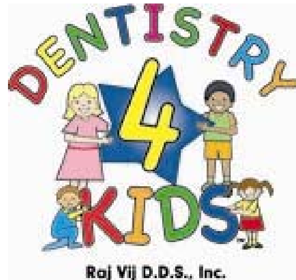


Board Certified Pediatric Dentist

3523 Commercial Dr. **Tel # 330-668-9977**
Fairlawn, OH 44333 **Fax# 330-668-9988**

Dear Parent,

Welcome to "**DENTISTRY 4 KIDS**", we are looking forward to serving all aspects of your child's dental needs. The best dental service is based upon a mutual understanding; therefore, we invite discussions regarding any aspect of your child's dental health.

Dr. Vij started out practicing as a general dentist in the Akron area in1992. Prior to returning to specialize in pediatric dentistry at University of Maryland, Baltimore, he served as the Director of Summit County Dental Services. Dr. Vij is also on staff at Children's Hospital of Akron, Summa Hospital as well as other surgery centers in the area. He is a Diplomate of the American Board of Pediatric Dentistry. This office intends to offer comprehensive, quality dental care for infants, children, and adolescents.

At the first visit Dr. Vij will complete an examination of all hard and soft tissues for proper growth and development. He or the dental hygienist will perform a cleaning and fluoride treatment. We will only take x-rays necessary for proper diagnosis and treatment. If you have been referred from another dentist, the reason for the referral will be addressed at the first visit. A check up may or may not be completed, depending on evaluation. Dr. Vij will consult with parents at the completion of the visit to discuss the treatment as well as any future needs. We do encourage the children to come back to the operatory by themselves for all appointments. This helps us to develop a one on one relationship with the child and allows us to devote undivided attention to the patient.

The office is located behind the day care center off Cleve-Mass Rd. just south of Giant Eagle on Commercial Dr:

Dentistry 4 Kids
3523 Commercial Dr.
Fairlawn, Ohio 44333
330-668-9977
Website: **www.dentist4kidz.com**

Our goal is to help our patient's enjoy their visit to their dentist! We can help achieve this goal with regular preventive care. Our Staff is well trained and loves working with children.

Thank you for choosing our office and we look forward to meeting you on:

________________________________ at __________ AM / PM. Please fill out the attached information and bring with you to your appointment! Thanks again!

Sincerely,

Raj Vij D.D.S. & Staff

Welcome to Dentistry 4 Kids/Raj Vij D.D.S Inc.
Board Certified Pediatric Dentist

General Information

Date:______________

Child's Name:______________________________ Child's Nickname: ___________________
First Last M.I.

Child's Birthday: __________________ (MM / DD / YYYY) Child's Age: ___________ Male □ Female □

Home Address____

____
City State Zip

□ **Father** □ **Step** □**Guardian**

Name:_______________________

SS#_________________________

Father's Birthday: ____________

Home Ph.: ________________

Cell Ph.:___________________

Work Ph.: _________________

May we call you at work?______

Employer:_________________

Email:_____________________

OK to confirm appointments at above E-mail? YES/NO

□ **Mother** □ **Step** □**Guardian**

Name:__________________

SS#_____________________

Mother's Birthday:__________

Home Ph.:_______________

Cell Ph.: ________________

Work Ph.: ________________

May we call you at work?_____

Employer:________________

Email:___________________

OK to confirm appointments at above E-mail? YES/NO

Marital Status:
Married □ Single □
Widowed □ Divorced □
Partnered □ Separated □
Child resides with □ Mom □ Dad □ Both

Who is accompanying the patient? ________________

Who is responsible for the account?_________________

******Note The adult bringing the child is responsible for full payment.******

Is your child adopted? _______

Is your child in foster care?________

Who may we thank for referring your child to our office?

____

Insurance Information

Primary Insurance **Subscriber**__________________________________

Dental Insurance Co.:__________________________________Ph. #______________________

Insurance Co. Address: ____
City State Zip

Employer: _____________________________Group Number: _____________

Employer Address____

Secondary Insurance **Subscriber**__________________________________

Dental Insurance Co.:____________________________________Ph. #____________________

------------- **OVER**-----------

Financial Policy

Thank you for choosing us as your health care provider. We are committed to your child's treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment.

Full payment is due at the time of service.

We accept Cash, Checks, Money Orders, Visa/Mastercard, American Express and Discover. Extended Payment Plan arrangements must be made in advance of the appointment with credit approval.

Regarding non-Contractual Insurance:

We do accept assignment of insurance benefits for your visit. However, we do require your percentage of bill to be paid at the time of service. The balance is your responsibility whether your insurance pays or not. We are unable to bill your insurance company unless you give us your insurance information by either a signed original claim form or a card. Your insurance is a contract between you and your insurance company. We are not party to that contract. As a courtesy, we do accept most insurance types. In the state of Ohio, the law requires insurance companies to pay claims within 30 days or less. Please be aware that some, and perhaps all, of the services provided may be non-covered services and considered reasonable and necessary under some insurances.

Regarding Insurance Plans where we are a participating provider:

All co-pays and deductibles are due prior to treatment. Failure to collect at time of service may void your contract eliminating future dental/medical care by the subscriber or dependents. In the event that your insurance coverage changes to a plan where we are not a participating provider, refer to the above paragraph.

Usual and Customary Rates:

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. We are a specialty practice. You are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates unless we are contracted with them to accept their changes.

Collections Accounts:

Accounts over 90 days from date of service are subject to be placed with a collection agency. A 40% collection fee will be added to your account. Any costs incurred, will be responsibility of the account holder. If parents are divorced, both parents are responsible for paying the account. We do not get involved in 3rd part billing or divorce decrees.

Minor Patients:

The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. If anyone other than the above brings the child in, a check must be sent with him or her to cover services performed that day.

Missed Appointments:

Our policy is not to charge for missed appointments, however, if you miss 2 appointments without a 24 hour notice, on your 3rd missed appointment, you will be charged $60.00, the rate of a normal office visit. Please help us to better serve you, and other patients, by keeping scheduled appointments. All NSF checks will be charged $30.00 due to the fact that our bank charges our office.

Thank you for understanding our Financial Policy. Please let us know if you have any questions.

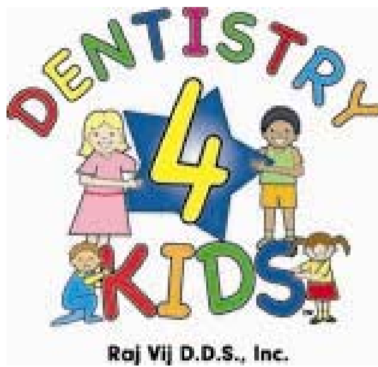
I have read this Financial Policy. I understand and agree with this Financial Policy.

I affirm that the information I have given is correct to the best of my knowledge. It 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 the necessary dental services my child may need.

I certify that my child is covered by ______________________Insurance Co. and I assign directly to Dr Vij all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any co-payment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

____

Signature of Parent or Guardian



Board Certified Pediatric Dentist

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Fairlawn, OH 44333 **Fax# 330-668-9988**

Child's Name____ Male □ Female □ Age_____ Date of Birth______________
(First) (Last)

Names and ages of brother and sisters ____

Child's Pediatrician or Family Practice Physician______________________ Recent Physical Exam (approximate date): ____________

Name of family dentist_________________________Did they refer you to us? **Yes / No**. App. Date of last visit___________

In order to get to know your child better, we would appreciate your taking the time to provide the following information.

CHILD'S MEDICAL HISTORY -- please circle appropriate answer or fill in the blank line:

1. Does **your child have [please circle]:**

Heart Murmur: Yes / No If yes, Were you referred to a Cardiologist for an evaluation? Yes / No

Cardiologist's name: ________________________ Phone____________

Allergies or allergic reactions: Please specify ____

Nervous or emotional problems: Please specify ____

2. Has **your child had [please circle]:**

General Anesthesia
Circulatory Problems
Bleeding Disorder
Abnormal Bruising
HIV
A.I.D.S.
Asthma
Breathing Problems
Tonsil or Adenoid Trouble
Tonsils and/or Adenoids Removal
Chronic Sinus Problems
Headaches
Pain Around Eyes
Earaches
Ear Tubes
Eczema
Epilepsy
Seizures
Behavioral Concerns
Mental Retardation
Attention Deficit Disorder**/ A.D.D**.
Attention Deficit Hyperactivity Disorder /**A.D.H.D.**
Hyperactivity
Down Syndrome
Rheumatic Fever
Brain Damage
Developmentally Delayed
Autism
Cerebral Palsy
Cancer
Leukemia
Lyme Disease
Diabetes
Kidney Disease
Liver Disease
Hepatitis
Rheumatoid Arthritis
None of these conditions
Other: _________________________
____
____
____
____

Is your child **in good health**? Yes / No If not, describe condition? ____

Allergies or allergic reactions None / Yes If yes, please specify: ____

Has your child ever had a **reaction to other medications**? List medication: _______________Describe reaction: ________________

Is your child **currently on medication**? Yes / No If yes, please list: ____

Has your child **had a hospital admission**? Yes / No If yes, why? ____

Has your child **had any major trauma**? Yes / No If yes, describe: ____

Has your child **had surgery** /operations? Yes / No If yes, describe why & where: ____

Does your child have **any limitations to physical activities**? Yes / No If yes, describe: ___________________________________

CHILD'S DENTAL HISTORY -- please circle appropriate answer or fill in the blank line:

Primary reason for today's visit: ____

Is there any **pain while chewing**? ________________________Is the pain keeping the child up at night? Yes / No / Occasionally

Has your child been seen by a Dentist? Yes / No Name of Dentist: _______________________App Date: ___________________

Has your child had **dental x-rays** taken? Yes / No If yes, approximate date_______________________

Do you have **city or well water**? City / Well Do you use a "**Reverse Osmosis**" filter system Yes / No **Bottled Water** Yes / No?

Is your child **taking fluoride tablets or drops** now? Yes / No Has taken fluoride supplement in the past? Yes / No

Has your child **had local anesthesia** (novocaine)? Yes / No Has your child had nitrous oxide during a dental procedure? Yes / No

Are you **satisfied with the appearance of your child's teeth?** Yes / No

Do you feel your child has **an orthodontic problem?** Yes / No Please explain____

Please name your **child's favorite snacks**: ____

Does your child suck **a thumb or finger**? Yes / No Which one: Thumb / finger(s) When? Day____Night_____Both_______

Did your child **EVER suck a thumb, finger(s), or pacifier**? Yes / No **Which one**: _______ What **age did they stop**? _________

PLEASE CIRCLE IF ANY PERTAIN TO YOUR CHILD'S DENTAL HISTORY:

Grinds teeth at night	Biting hard objects	Bleeding gums	Jaw trauma
Tongue thrust	Dental extraction	Hard to swallow	Other______________
Mouth breathing	Dental decay	Mouth odor	
Lip biting or sucking	Neck swelling	Jaw clicking	
Nail biting	Face swelling	Jaw popping	

FAMILY'S MEDICAL AND DENTAL HISTORY:

Which member in the **immediate** family has a history of:
Allergies: Mom / Dad / Brother / Sister. Allergic to what:____
Diabetes: Mom / Dad / Brother / Sister Gum disease: Mom / Dad / Brother / Sister
High decay rate: Mom / Dad / Brother / Sister No / Minimal dental decay: Mom / Dad / Brother / Sister
Extra or missing teeth: Mom / Dad / Brother / Sister / Grandparent. Which did they have? Extra teeth / Missing teeth
Orthodontic concerns: Mom / Dad / Brother / Sister
Had orthodontic treatment (which member(s)? _____________________ Name of Orthodontist______________________

CHILD'S SOCIAL HISTORY [where applicable]

Is your child shy? Yes / No Does your child **adjust well to new situations**? Yes / No

Does your child **fear the pediatrician**? Yes / No Has your child **reacted well to previous dental treatment**? Yes / No

If your child has not had any previous dental treatment, does your child react well to haircuts? Yes / No

Do you have any other concerns or is there anything else significant about your child that you would like to mention?
____

____

Parent / Guardian's signature _________________________ Relationship to patient: ________________ Date: _________