Dr. Jaish J. Markos
State License #053850
50 Dayton Lane
Ste #103
Peekskill, NY 10566
Phone: (914) 402 – 6980
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PATIENT REGISTRATION

Date_____

1. Tell Us About Your Child

Child's First Name_____Middle Initial_____ Last Name_____

Nickname (if any) _____ Date of Birth_____☐ Male ☐ Female

What are your child interests/hobbies?

_____

Social Security # _____ Home Phone _____

Home Address_____

City_____ State_____

ZIP_____

School_____Grade_____

Siblings_____

2. Mother's/Guardian's Information

Name: _____

Birth Date:_____

Home Phone: _____

Cell Phone:_____

Address: _____

City: _____

State:_____ Zip:_____

Employer: _____

Email: _____

3. Father's/Guardian's Information

Name:_____

Birth Date: _____

Home Phone: _____

Cell Phone:_____

Address: _____

City: _____

State:_____ Zip:_____

Employer: _____

Email: _____

4. Who Is Accompanying the Child Today?

Name: _____

Relationship:_____

Do you have legal custody of this child?

☐ Yes ☐ No

5. Responsible Party Information

Name:_____

Birth Date: _____

Home Phone: _____

Cell Phone:_____

Address: _____

City: _____

State:_____ Zip:_____

6. Primary Dental Insurance

Insurance Company Name

_____

Insurance Company Address

_____

_____

Insurance Company

Phone#_____

Group # (Plan, Local, or Policy#)

_____

Policy Owner's Name_____

Relationship to Patient

_____

Policy Owner's Birth Date

_____

Social Security #

_____

Policy Owner's Employer_____

7. Secondary Dental Insurance

Insurance Company Name

_____

Insurance Company Address

_____

_____

Insurance Company

Phone#_____

Group # (Plan, Local, or Policy#)

_____

Policy Owner's Name_____

Relationship to Patient

_____

Policy Owner's Birth Date

_____

Social Security #

_____

Policy Owner's Employer_____

How did you hear about our office? Or who may we thank for the referral?

_____

PATIENT MEDICAL HISTORY

Patient's Name_____ Birth Date_____

	YES	NO		YES NO
Heart Murmur	☐	☐	Asthma	☐ ☐
Heart Disease	☐	☐	Lung Disease	☐ ☐
Cardiac, Pacemaker	☐	☐	Tuberculosis	☐ ☐
High Blood Pressure	☐	☐	Epilepsy	☐ ☐
Rheumatic Fever	☐	☐	Nervous Disorder	☐ ☐
Prolonged Bleeding When Cut	☐	☐	Chemical Dependency	☐ ☐
Blood Transfusion, Date_____	☐	☐	HIV/AIDS	☐ ☐
Cancer, Tumor	☐	☐	Metallic Implant	☐ ☐
Kidney Disease	☐	☐	Glaucoma	☐ ☐
Diabetes	☐	☐	Is the patient pregnant?	☐ ☐
Hepatitis, Liver Disease	☐	☐	Bleeding Gums	☐ ☐
Thyroid Disease	☐	☐	Bad Breath	☐ ☐
Cold Sore, Fever Blister	☐	☐	Puberty/Growth Spurt	☐ ☐
Drug/Food Allergy	☐	☐	Latex Allergy	☐ ☐

Patient's Name_____ Birth Date_____

Any allergy to Medications/Food(s):

_____

_____

_____

Is there any other health information that should be known?

_____

_____

_____

_____
_____

Is the patient taking any medications? ☐ Yes ☐ No If yes, please list the medications and reasons:

_____
_____
_____

Has the patient recently been under the care of a physician or had a serious illness or operation in the last 5 years?
☐ Yes ☐ No If Yes, please explain

_____
_____
_____
_____
_____
_____

Name & Phone Number of the patient's Physician:

_____
_____
_____

Is this your child's first dental visit? ☐ Yes ☐ No

Last Dental Visit: _____ Dentist's Name & Phone Number:

_____
_____

Does the patient have a specific dental problem that needs attention? ☐ Yes ☐ No
If yes, please explain:

_____
_____
_____

Has the patient experienced any unfavorable reaction from any previous dental or medical care? ☐ Yes ☐ No If yes, please explain:

_____
__

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of 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.

_____	_____	_____
Signature of Parent/Guardian	**Date**	**Relationship to Patient**

Gentle Care Pediatric Dentistry

50 Dayton Lane, Ste #103, Peekskill, NY 10566
914-402-6980

OFFICE POLICIES

CANCELLATION POLICY: Any cancelled appointments with less than 24 hours notice from the scheduled appointment time is subject to a $25.00 charge per patient. For example, if an appointment is scheduled with Dr. Markos at 9:00AM and the appointment is cancelled at 3:00PM the day before, this is defined as a "cancelled appointment". Gentle Care Pediatric Dentistry does not double-book appointments; hence, our office only schedules one appointment per allotted half-hour. Therefore, if there are any cancelled appointments, our office would like to contact other patients who need our care. Any siblings that are booked together are considered two appointments (hence, a one hour appointment). If our office schedules a set of siblings together and there is one cancellation, we will not be able to book any siblings together in the future on the same day. Dr. Markos respects the valued time while he is treating his patients and in turn would appreciate for his time to be respected.

CONFIRMATION POLICY: All appointments at Gentle Care Pediatric Dentistry require a CONFIRMATION (phone call, email or message on the office answering machine). Our office will attempt to contact the child's parent/guardian the day prior to your scheduled appointment. If we do not reach you, we will try contacting you again before our office is closed. At this time, we require a confirmation for your appointment at (914)402-6980. Feel free to email us at www.gckidsdmd@gmail.com. Please leave a message on our answering machine after business hours. You may also call us at any time to confirm your appointment.

FINANCIAL POLICY:

PATIENTS WITH INSURANCE COVERAGE: Gentle Care Pediatric Dentistry obtains an insurance verification for all patients. For any treatment preformed, a pre-estimate based on your insurance benefits will be provided to help you obtain the appropriate benefit from insurance carrier. We bill your insurance carrier as a courtesy to you. However, you are responsible for the payments of the account. Any portions of the bill that are not paid by the insurance company are the responsibility of the parent/guardian. Sometimes there is a co-payment required by you as per your insurance agreement. Even if you have double insurance coverage (this is possible if you and your spouse both have insurance), there still may be a portion that will be your responsibility. If you are having treatment over a period of time, payment is due when services are rendered.

PATIENTS WITHOUT INSURANCE COVERAGE: Patients without insurance coverage are required to pay for services when they are rendered.

ADDITIONAL TERMS: For your convenience, we accept Visa, MasterCard, Check and Cash payments. There will be a charge for any duplication of X-Rays. Depending on the X-Ray(s) in question a charge between $5.00-$25.00 will be administered. Patients are not authorized to remove the originals from the premises. Any checks that are returned are subject to a $25.00 charge. In addition, any other bank fees that are incurred are the responsibility of the parent/guardian. If there are any balances on the patient's account, no appointments will be scheduled. Accounts unpaid after 30 days from the date of billing are subject to a finance charge at the rate of ½% per month (6% per annum). If your account is referred for collection, you will be responsible for collection costs in the amount of 30% of the outstanding balance, together with court costs and reasonable attorney's fees.

We would like to take the opportunity to welcome you to **GENTLE CARE PEDIATRIC DENTISTRY** and assure you that we will do our utmost to provide you with the best care possible!

I HAVE READ AND UNDERSTAND THE CANCELLATION, CONFIRMATION AND FINANCIAL POLICIES OF GENTLE CARE PEDIATRIC DENTISTRY.

_____ _____

Signature of Parent or Guardian **Date**