

MINOR FORM



Something to Smile About

Ross Dental Group
3825 Kraus Ln, Unit J
Fairfield, OH 45014
513-738-2606

TO INCREASE THE LEGIBILITY OF SCANNED DOCUMENTS, PLEASE PRESS FIRMLY

PATIENT INFORMATION TO BE COMPLETED BY THE RESPONSIBLE PARTY Today's Date _____

PATIENT'S LEGAL First Name _____ Middle _____ Last Name _____

Preferred Name / Nickname _____ Patient Cell Number _____

Cell number used only after the Patient is 18.

Date of Birth _____ Age _____ Gender _____

1st Parent Name: _____ What is your relationship to the dependent child? _____

Address _____ DOB: _____

City _____ State _____ Zip _____

Parent Ph. _____ Work Ph. _____ Parent Cell Ph.* _____ Text: yes / no

*** WE ARE ONLY ABLE TO SEND TEXT MESSAGES NOTIFICATIONS TO ONE PHONE # PER PATIENT

Parent Email _____

2nd Parent Name: _____ What is your relationship to the dependent child? _____

Address _____ DOB: _____

City _____ State _____ Zip _____

Parent Ph. _____ Work Ph. _____ Parent Cell Ph.* _____ Text: yes / no

Parent Email _____

Is there anyone else (guardian, biological parent, adoptive parent, step parent) that may have **legal access** (this is different than granting a person PoA) to information pertaining to this patient?

Name: _____ Ph#: _____ Relationship to the patient: _____

PATIENT INSURANCE

Please select any of the following that apply:

Yes, my dental insurance has changed. (**ALERT THE FRONT DESK PRIOR TO BEING SEEN.**)

No, my dental insurance has not changed. (**YOU CAN SKIP TO THE NEXT SECTION.**)

I don't have insurance & will be paying today by cash or credit (Visa, MasterCard, Discover).

I am a current patient.

I am a new patient.

I am a returning patient (last seen more than 3 years ago).

Member ID# _____ Group # _____ Ins Company Ph # _____

Name of policy holder _____ Policy holder DOB _____

Relationship to Patient _____ Policy holder SSN _____ Policy holders Ph # _____

Have you used these dental benefits at any other office this year? Yes / No If yes, where? _____

Secondary Dental Insurance Company _____ Employer _____

Member ID# _____ Group # _____ Ins Company Ph # _____

Name of policy holder _____ Policy holder DOB _____

Relationship to Patient _____ Policy holder SSN _____ Policy holders Ph # _____

Have you used these dental benefits at any other office this year? Yes / No If yes, where? _____

*** PLEASE COMPLETE ALL SECTIONS ***

HEALTH INFORMATION

- Does your child take any medications? Yes No If yes, please list all medications, even over the counter medications & supplements.

- Is there anything we should know about your child to help make their visit more comfortable or to help us to treat them?

OVER PLEASE



Is your child under a physician's care for any specific medical condition? Yes No If yes, please explain _____
 Has your child been recently hospitalized or had a major operation? Yes No If yes, please explain _____
 Has your child had a serious head or neck injury? Yes No If yes, please explain _____
 Has your child ever been addicted to prescription or illegal drugs? _____

FEMALES:

Not Pregnant Pregnant: Due Date: _____ Nursing
 Taking Contraceptives. Please indicate what kind: _____

ALLERGIES:

No Known Allergies Latex Codeine Acrylic
 Aspirin Penicillin Sulfa Drugs Local Anesthetics
 Metal / Nickel Amoxicillin
 Any additional allergies not listed above? Yes No If yes, please explain _____

CIRCLE ALL THAT APPLY:

Acid Reflux	Bruises Easily	Frequent Headaches	Pain in Jaw Joints
ADD / ADHD	Cancer	Glaucoma	Parkinson's
AIDS / HIV +	-What Kind: _____	Heart:	Psychiatric Care
Alzheimer's Disease	-When?: _____	A-fib	Rheumatic Fever
Anaphylaxis/Severe Allergic Reaction	-Chemotherapy? _____	Heart Disease	Seasonal Allergies
Angina/Chest Pains	-When?: _____	Heart Attack	Shingles
Arthritis	-Radiation? _____	Irregular Heartbeat	Sleep Apnea
- Osteo	-When?: _____	Mitral Valve Prolapse	CPAP user? Yes No
-Rheumatoid	Chest Pains	Murmur	Sinus Trouble
Artificial Heart Valve	Cold Sores/Fever Blisters	Pacemaker	Stomach / Intestinal Disease / IBS
Artificial Joint	COPD	Hemophilia	Stroke
-Surgery Date: _____	Cortisone Medicine	Hepatitis A	Thyroid Disease:
-Which Joint: _____	Past or Present	Hepatitis B or C	Hypothyroidism
Anxiety	Dementia	Herpes	Hyperthyroidism
Asthma	Depression	High Cholesterol	Parathyroid Glands
Autism	Diabetes Type 1	Hives or Rash	Tonsillitis
Blood Disease	Diabetes Type 2	Hyperglycemic	Tuberculosis
Blood pressure; High	Dry Mouth	Hypoglycemic	Active or Inactive?
Blood pressure; Low	Empysema	Kidney Problems	Tumors or growths
	Epilepsy or Seizures	Lung Disease	
	Excessive Bleeding	Migraine	
	Fainting Spells / Dizziness /	Osteoporosis	

*** PLEASE COMPLETE ALL SECTIONS ***

Has your child had any other serious illness or condition not listed above? Yes No If yes, please explain: _____

RESPONSIBLE PARTY

Consent for Services & Financial Information: I understand that I am financially responsible for all charges whether or not paid or allowed by insurance.
 As a condition of my treatment by this office, I understand that payment is due at the time of service; Patients with or without dental insurance will be asked to pay their estimated portion at the time of service. As a courtesy, Ross Dental Group will submit claims to my dental insurance company on my behalf. I am responsible for notifying the office about any changes to my insurance policy. **Individual yearly maximums are typically shared by any dental specialist that is billing my insurance & any services received outside this office will affect any estimates presented to me. Dental insurance plans do not offer "free cleanings" as all services are paid from the yearly maximum. This means that if my yearly maximum is used for other services, my dental cleanings will be an out-of-pocket expense.** Predeterminations are only done at the Patients request & do not guarantee benefits. Insurance termination dates can be backdated & in network rates would not apply if this is the case. The relationship between Ross Dental Group & my insurance company is subject to change. Ross Dental Group will make an effort to advise our patients if this happens via email, phone, postal mail & lobby signage. It is my responsibility to make inquiries about insurance network affiliations. When yearly insurance maximums are reached, in network rates will not apply. It is my responsibility to keep my contact information up to date. Any balance carried more than 90 days can be sent to a third party collector. **I understand that Patients can be dismissed from the practice for excessive past due balances, late arrivals or missed appointments.**

Parents, Guardians or others bringing minors to appointments: By bringing the patient to the office to receive care, I understand that as the person requesting that the Providers at Ross Dental Group render care to the minor, I am responsible for the charges that result from said care. If there are any prior financial arrangements via court order or verbal arrangement, those arrangements are between those entities, not between Ross Dental Group and the Patient or the Responsible Party.

HIPAA: Notice of our HIPAA is clearly posted in our reception room as mandated by law. Your signature on this form is your acknowledgement of that. If you would like a written copy of our specific HIPAA policies, please ask an administrative member of our team.

I understand that Ross Dental Group asks for **48 business hours to cancel or change an appointment to avoid the \$75 cancellation fee.** I am aware that Ross Dental Group sends multiple reminders via telephone, text & email to help remind me about my appointments.

PARENT GUARDIAN / /



PARENTS Signature (or Guardian) Patient's Printed Name. Guardian's Name & Relationship to Patient Date Revised 1.1.2026