Patient Information

Patient Name:_____ DOB: _____ Age: _____

M / F Patient Lives With: _____

Mother's Name: _____ DOB: _____

Address: _____

Home #: _____ Cell #:_____ SSN: _____

Employer: _____ Work Phone: _____

Father's Name: _____ DOB: _____

Address: _____

Home #: _____ Cell #:_____ SSN: _____

Employer: _____ Work Phone: _____

Person Responsible for Account: _____

Relationship: _____ Email: _____

Billing Address: _____

Home #: _____ Cell #:_____

Dental Insurance

Insurance Company: _____ Group #: _____

Policyholder's Name: _____ Employer: _____

Policyholder's DOB: _____ Policyholder's SSN: _____

Relationship to Patient: _____

Dental History

Is this your child's first visit to the dentist? Y / N If not, how long since the last visit to the dentist? _____

Were any x-rays taken at previous dental visit? Y / N Have there been injuries to the teeth, face or mouth? Y / N
If yes, please explain: _____

Why did you bring the child to the dentist today? _____

Does the child have any of the following habits:

Lip Sucking/Biting Y / N Nail Biting Y / N Nursing/Bottle Habits Y / N Thumb/Finger Sucking Y / N

Has the child ever had a serious or difficult problem associated with previous dental work? Y / N
If yes, please explain: _____

Is the child's water fluoridated? Y / N Does the child take fluoride supplements? Y / N

Has the child ever had any pain or tenderness in his/her jaw/joint? (TMJ/TMD) Y / N

Does the child brush his/her teeth daily? Y / N Does the child floss his/her teeth daily? Y / N

Health History

Has the child ever had any of the following conditions?

Abnormal Bleeding	Y / N	Handicaps/Disabilities	Y / N
Allergies to any Drugs	Y / N	Hearing Impairment	Y / N
Any Hospital Stays	Y / N	Heart Murmur	Y / N
Any Operations	Y / N	Hemophilia	Y / N
Asthma	Y / N	Hepatitis	Y / N
Cancer	Y / N	HIV+/AIDS	Y / N
Congenital Heart Disease	Y / N	Kidney/Liver Conditions	Y / N
Convulsions/Epilepsy	Y / N	Rheumatic/Scarlet Fever	Y / N
Pregnancy	Y / N	Allergies to Latex	Y / N

Please discuss any serious medical conditions the child has had:
_____

Please list all drugs the child is allergic to:
_____

Please list all drugs the child is currently taking:
_____

Who may we thank for referring you? _____

Child's Physician: _____ Phone: _____

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 services my child may need.

_____ _____
Signature of Parent/Guardian Date

OFFICE USE
I have reviewed the medical/dental information above for the patient named herein. _____ _____
Doctor Date

Pediatric Smiles SM
Keeping Kids Smiling!

Notice of Privacy Practices
Patient Acknowledgement

Patient Name : _____Date of Birth : _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health information. The Notice includes :

- A statement that this practice is required by law to maintain the privacy of protected health information.
- A statement that this practice is required to abide by the terms of the notice currently in effect.
- Types of uses and disclosures that this practice is permitted to make for each of the following purposes: treatment, payment, and health care operations.
- A description of each of the other purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization.
- A description of uses and disclosures that are prohibited or materially limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that I may revoke such authorization.
- My individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to :
    - The right to complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint.
    - The right to request restrictions on certain uses and disclosures of my protected health information, and that this practice is not required to agree to a requested restriction.
    - The right to receive confidential communications of protected health information.
    - The right to inspect and copy protected health information.
    - The right to amend protected health information.
    - The right to receive an accounting of disclosures of protected health information.
    - The right to obtain a paper copy of the Notice of Privacy Practices from this practice upon request.

This practice reserves the right to change the terms of its Notice of Privacy Practices and to make new provisions effective for all protected health information that it maintains. I understand that I can obtain this practice's current Notice of Privacy Practices on request.

Signature : _____Date : _____

Pediatric Smiles℠
Keeping Kids Smiling!

Broken Appointment Policy

When appointments are scheduled, it is the parent or guardian's responsibility to keep the appointment. If at anytime you wish to change an appointment, you are required to call at least 24 hours in advance to cancel or reschedule the appointment.

If the patient fails to show for a scheduled appointment OR fails to cancel the appointment at least 24 hours in advance, a thirty day suspension will be placed on rescheduling that appointment. A second broken appointment will also result in a thirty day suspension and require a $50.00 deposit toward the appointment to reschedule. A third broken appointment receives a thirty day suspension and requires pre-payment of the appointment to reschedule; should the patient fail the last rescheduled appointment, the pre-payment will remain on the account until the end of the year—the family will remain on this status for a period of one year.

_____ _____

Parent/Legal Guardian Date

Guarantor's Policy

As a courtesy we will file your insurance, please be advised that verification of your benefits is not a guarantee of payment. Your insurance company will review the claim and pay according to your coverage.

If your account becomes 90 days overdue, you are responsible for the account balance as well as the collection fees mandated by our outside collection agency.

Therefore by signing this form, you are accepting responsibility for any claims or balances not paid by your insurance company and any fees assessed due to the hiring of an outside collection agency.

_____ _____

Guarantor's Signature Date

Authorized Parties

Please complete the information below listing anyone authorized to bring your child(ren) to their dental appointments. Patients brought to an appointment without an authorized adult will be rescheduled.

_____ _____

Authorized Party Relationship to Patient

_____ _____

Authorized Party Relationship to Patient

_____ _____

Authorized Party Relationship to Patient

_____ _____

Authorized Party Relationship to Patient

NO food or drink is permitted inside the building. _____

Initials