Welcome!

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date ______________________ Birthdate ____________

Name of Minor/Child ______________________________________ Sex ❏ M ❏ F Age __________
Last Name First Name Middle Initial

Nickname ____________________ Hobbies ______________________

Home Address ____
Street City State Zip

Mailing Address ____
Street City State Zip

Person financially responsible ____

Whom may we thank for referring you? ______________________________________

PARENT/GUARDIAN INFORMATION

Father's/Guardian's Name ________________________

Address (if different from patient's) ________________________

____

Home Phone (____) __________ Work Phone (____) __________

E-mail ________________ Cell Phone (____) __________

Employer ______________________________________

Soc. Sec. # ______________ Birthdate ____________

Do you have dental insurance coverage for minor/child? ❏ Yes ❏ No

Carrier: ______________ Phone (____) __________

Address ______________________________________

Group # ______________ Subscriber ID: __________

Mother's/Guardian Name ________________________

Address (if different from patient's) ________________________

____

Home Phone (____) __________ Work Phone (____) __________

E-mail ________________ Cell Phone (____) __________

Employer ______________________________________

Soc. Sec. # ______________ Birthdate ____________

Do you have dental insurance coverage for minor/child? ❏ Yes ❏ No

Carrier: ______________ Phone (____) __________

Address ______________________________________

Group # ______________ Subscriber ID: __________

Is your child eligible under the Idaho Smiles Program? ❏ Yes ❏ No

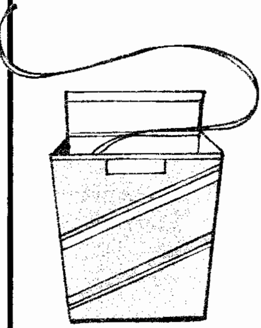
Idaho Smiles # ______________________

DENTAL HISTORY

Date of last visit to a dentist ____________________ For what service? ____________________

	YES	NO
Has child complained about dental problems?	❏	❏
Does child brush teeth daily?	❏	❏
Does child use floss every day?	❏	❏

	YES	NO
Is flouride taken in any form?	❏	❏
Any injuries to mouth, teeth, head?	❏	❏
Any unhappy dental experiences?	❏	❏
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc.?	❏	❏



MEDICAL HISTORY

Minor/Child's Physician ______________________ City/State ______________________ Phone (____) ____________

Date of last physical examination ______________________

	YES	NO
Receiving any medication or drugs?	❑	❑
Ever been hospitalized?	❑	❑
Ever had surgery?	❑	❑
Is there excessive bleeding when cut?	❑	❑

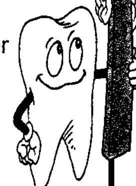
Medications ______________________________

____

____

Allergies ______________________________

____



Has minor/child had any history of or difficulty with any of the following? If yes, please check (✓).

❑ A.I.D.S./H.I.V.	❑ Cerebral Palsy	❑ Epilepsy	❑ Kidney Disease	❑ Rheumatic Fever
❑ Anemia	❑ Chicken Pox	❑ Fainting	❑ Liver Disease	❑ Sinus Problems
❑ Asthma	❑ Convulsions	❑ Hearing Problems	❑ Measles	❑ Thyroid Disease
❑ Bladder Problems	❑ Diabetes	❑ Heart Problems	❑ Mononucleosis	❑ Tuberculosis
❑ Cancer	❑ Drug/Alcohol Abuse	❑ Hepatitis	❑ Mumps	❑ Other

Is there any disease, condition or problem that is not listed above?

Please describe ____

EMERGENCY CONTACT

Name of nearest friend or relative, in case of emergency. (Person Not Living With You)

Name ______________________________ Relationship ____________________ Phone (_____) ____________

Name ______________________________ Relationship ____________________ Phone (_____) ____________

AUTHORIZATIONS

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health. Int. ________

Minor/Child Consent

I am the parent, guardian, or personal representative of ______________________________

Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered. ______________________________

Signature of Parent/Guardian

Insurance Assignment and Release

As a courtesy to you, we will process your insurance forms and claims. However, your insurance policy is an agreement you have with your insurance carrier. If you have questions regarding payments from your insurance company, we recommend that you call your insurance provider directly for the most accurate and speedy answer. It is the parent's/guardian's responsibility to pay for any deductible or other balance not covered by the insurance. Regardless of insurance, I agree the balance will be paid in full within 60 days of treatment. I certify that my dependent is covered by insurance with ______________________ and

Name of Insurance Carrier

assign all insurance benefits directly to Smiles 4 Kids. I authorize the use of my signature on all insurance submissions. I give permission for Smiles 4 Kids to use health care information and may disclose such information for the purpose of obtaining payment for service and determining insurance benefits.

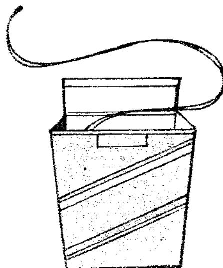
______________________________ Signature of Parent/Guardian

______________________________ Print name of Parent/Guardian

______________________________ Relationship to Patient

______________________________ Date

UPDATE



TO BE COMPLETED AT LATER VISIT

Has there been any change in patient's health since last dental appointment? ❑ Yes ❑ No

If yes, please describe ______________________________

Is patient taking any new medications? ❑ Yes ❑ No If yes, please list

Date ____________________ Parent/Guardian Signature ______________________________

Date ____________________ Dentist Signature ______________________________

No Show/Cancellation Policy

Dear Parent:

We understand that there are legitimate reasons for having to cancel and appointment. However, due to the demand for the doctor, all cancellations must allow adequate time to offer that appointment to another patient who needs to see the doctor. Please let this serve as notice to you, if you fail to give 24 hours notice of cancellation, there will be a $50.00 fee billed to your account that will not be paid by insurance or Medicaid and you are responsible for the full amount.

[NOTE: If there is more than 1 patient in same family, please list ALL patients]

Name of Patient: ____

Phone Number: ____

Signature of parent or guardian: ____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

* You May Refuse to Sign This Acknowledgement *

I, _________________________ , have received a copy of this office's Notice of Privacy practices. I acknowledge that I have had the full opportunity to read the Notice of Privacy Practices.

[NOTE: If there is more than 1 patient in same family, please list ALL patients]

Name of Patient: ____

Phone Number: ____

Signature of parent or guardian: ________________________________ Date: ______________________

FOR OFFICE USE ONLY – Where Responsible Party/Parent/Legal Guardian Does NOT Sign

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ ___Individual refused to sign
- ☐ ___Communication barriers prohibited obtaining the acknowledgement
- ☐ ___Emergency situation prevented us from obtaining acknowledgement
- ☐ ___Other (Please Specify) ____
  ____

____

Signature of Office Representative (only if Acknowledgement not signed above).