

## Patient's Information

Patient's Name: Last	First	MI:	Sex: <b>M</b> <b>F</b>	Age:	DOB:
Place of Birth:	SS#	-	-	School:	Grade: City:
Has patient had any bad dental or medical experiences in the past? <b>Yes</b> <b>No</b> If YES, please explain:					
How can we make this a more positive experience for patient?					
Whom may we thank for referring you to our office?					

## Dental History

Reason for today's visit:	Patient's Pediatrician:	City:
Is this the patient's first dental visit? <b>Yes</b> <b>No</b> Date of last X-rays?	Date of last Physical:	Phone:
If No, date of last visit?	Was your child breast fed? <b>Yes</b> <b>No</b> If Yes, until what age?	
Treatment Completed	Was your child bottle fed? <b>Yes</b> <b>No</b> If Yes, until what age?	
Name of former dentist:	Phone:	Is patient in good health? <b>Yes</b> <b>No</b>
General or Pediatric Dentist?	City:	Are patient's immunizations up to date? <b>Yes</b> <b>No</b>
Has patient ever had any injuries to his/her: Teeth Mouth Head Jaws If yes, please describe:		Does patient have any allergies or reactions to any medications (example: Latex, Dental Anesthetics, etc.)? If so, to what? <b>Yes</b> <b>No</b>
Does patient receive fluoride in any of the following forms? Vitamins Water Toothpaste Tablets Drops in Rinse Gel		Does patient brush and floss daily? <b>Yes</b> <b>No</b>
<b>WOMEN ONLY</b> (ages 12 and older) - Are you: Pregnant? Yes No DK Taking birth control pills or hormonal replacement? Yes No DK Nursing? Yes No DK	Number of weeks	Does patient have any of the following mouth habits? Finger Sucking Thumb Sucking Lip Sucking Tongue Thrusting Mouth Breathing Teeth Grinding Nail Biting Pacifier Other (please describe):
		Does patient use tobacco (smoking, snuff, chew, bidis)? <b>Yes</b> <b>No</b> <b>DK</b>

### Has patient ever been diagnosed as having any of the following conditions?

AIDS	<b>Yes</b> <b>No</b>	Hemophilia	<b>Yes</b> <b>No</b>	Brain Injury	<b>Yes</b> <b>No</b>	Tuberculosis	<b>Yes</b> <b>No</b>
Hyperactivity	<b>Yes</b> <b>No</b>	Nutritional Deficiency	<b>Yes</b> <b>No</b>	Bruising Easily	<b>Yes</b> <b>No</b>	Blood Transfusions	<b>Yes</b> <b>No</b>
Anemia	<b>Yes</b> <b>No</b>	Child / Sexual Abuse	<b>Yes</b> <b>No</b>	Spina Bifida	<b>Yes</b> <b>No</b>	Excessive Gagging	<b>Yes</b> <b>No</b>
Kidney Disease	<b>Yes</b> <b>No</b>	Bladder Condition	<b>Yes</b> <b>No</b>	Liver Disease	<b>Yes</b> <b>No</b>	Rheumatic Fever	<b>Yes</b> <b>No</b>
Leukemia	<b>Yes</b> <b>No</b>	Developmental Delay	<b>Yes</b> <b>No</b>	Asthma	<b>Yes</b> <b>No</b>	Sickle Cell Anemia	<b>Yes</b> <b>No</b>
Autism	<b>Yes</b> <b>No</b>	Epilepsy	<b>Yes</b> <b>No</b>	Tonsil Problems	<b>Yes</b> <b>No</b>	Cancer or Malignancies	<b>Yes</b> <b>No</b>
Diabetes	<b>Yes</b> <b>No</b>	Hepatitis	<b>Yes</b> <b>No</b>	Bone or Joint Problems	<b>Yes</b> <b>No</b>	Convulsions / Seizures	<b>Yes</b> <b>No</b>
Oral Ulcers	<b>Yes</b> <b>No</b>	Ear Infections	<b>Yes</b> <b>No</b>	Hearing / Speech Problems	<b>Yes</b> <b>No</b>	Orthopedic Problems	<b>Yes</b> <b>No</b>
Eye Problems	<b>Yes</b> <b>No</b>	Heart Problems	<b>Yes</b> <b>No</b>	Cerebral Palsy	<b>Yes</b> <b>No</b>	Emotional Disturbance	<b>Yes</b> <b>No</b>

Please describe any current medical treatment including drugs, pending surgery, recent injuries, hospitalizations or any other information we should be aware of that has not been covered:

Does patient need to take an antibiotic to pre-medicate prior to dental treatment?	<b>Yes</b> <b>No</b>
Doctor's Signature / Medical History Reviewed:	Date:

## Parent's Information

Who is accompanying this child today?	Relationship:	Do you have legal custody of this child? <b>Yes</b> <b>No</b>
<b>Mother's Full Name:</b>	<b>Father's Full Name:</b>	
Address:	Address:	
City: State: Zip:	City: State: Zip:	
Home Phone: Cell Phone:	Home Phone: Cell Phone:	
Work Phone: Email:	Work Phone: Email:	
Date of Birth: SS#:	Date of Birth: SS#:	
Driver License#: State:	Driver License#: State:	
Occupation: Name of Employer:	Occupation: Name of Employer:	
Address of Employer:	Address of Employer:	
City: State: Zip:	City: State: Zip:	
Marital Status: Single Married Divorced Separated	Who does the patient live with? Both Mother Father Other	
Name of person responsible for this account: Address if not listed above:		

## Emergency Contact

In Case of Emergency, who should we contact? (Please specify someone who does not live in your household)

Name:

Relationship:

Phone:

## Dental Insurance Information

If your child is covered by dental insurance, please complete the following to insure proper processing of insurance claims:

Primary Dental Insurance  
Policy Holder's Name:

Secondary Dental Insurance  
Policy Holder's Name:

SS#: Date of Birth:

SS#: Date of Birth:

Insurance Company: Phone:

Insurance Company: Phone:

Address of Insurance Company:

Address of Insurance Company:

Group Policy Number: Local Number:

Group Policy Number: Local Number:

Relationship to Patient:

Relationship to Patient:

## Authorization

*I affirm that the information I have provided regarding my child is correct to the best of my knowledge. I understand it is my responsibility to inform Make A Smile of any changes related to my child's medical history. I authorize Make A Smile Children's Dental's doctors and staff to perform any necessary dental treatment my child may need. I authorize Make A Smile to release any information, including the diagnosis and records of any treatment or examination rendered to my child during such dental care, to third party payers and / or health practitioners. I authorize and request my primary and / or secondary insurance company(s) to pay directly to the dentist. I understand that my dental insurance carrier(s) may pay less than the actual bill for services. I also agree to assume full financial responsibility for all treatment rendered and, if necessary, collection costs and interest.*

I acknowledge that I have received the Dental Materials Fact Sheet, Notice of Privacy Practices.

Please enter your name above. You will sign the document later in our office.

Signature of Parent / Guardian

Relationship to Patient

Date

## Financial Policy

We appreciate and are honored to provide the best dental care possible. We value our relationship with you and believe that the best relationships are based upon understanding. We would like to familiarize you with our financial policies and reassure you that we do everything possible to insure our patients receive the maximum benefits possible from their insurance carriers. With the number of patients and myriad of plans we deal with on a daily basis, **we must rely on you to know and provide us with the basics of your insurance plan coverage, your eligibility and treatment history.** Upon your first visit, we will request a copy of your dental insurance card and any insurance information, which will allow us to file your claim (as a courtesy) for this and all future visits. Please remember to bring all dental insurance information as well as insurance card(s). We also ask that you notify us promptly of any changes in your coverage.

In order for you to be treated at Make A Smile Children's Dental, full payment is expected at the time of services unless you are insured. Prior to providing any treatment, we provide you with a cost estimate indicating our total fee. If you are insured we require deductibles and co-payments at the time services are rendered. We will try to verify eligibility prior to the initial visit to provide estimated insurance coverage. In the event your insurance company informs us of lack of coverage, you are responsible for the charges at the visit. If we are unable to verify eligibility because you are unable to provide your correct insurance information, you are expected to pay in full and obtain reimbursement from your insurance carrier. For your convenience we can provide an estimate of our fees for the first visit prior to your appointment. In the event we are unable to contact the insurance company, we will collect 100% of the cost of the visit, and upon the insurance reimbursement will refund the credit or bill the balance. In the event your insurance carrier only releases payment directly to you, full payment is expected at the time service is rendered unless other prior arrangements have been discussed.

We accept most dental insurance plans, except for those insurance plans that limit you to dental offices on a restricted list. Such plans require participating dentists to drastically reduce fees in exchange for exposure to thousands of potential patients. In contrast, we believe in individual attention with an emphasis on quality of care, not quantity, and we will never compromise our approach to personal dental care.

Please remember that your appointment time is reserved especially for you, so we need to be notified as soon as possible if you are unable to attend. Phone the office 48 hours in advance if cancellation is unavoidable so that we may give this special time to another patient. If 48 hours notice is not provided there may be a **\$50** charge.

In the circumstances involving divorced or separated parents, the person who has signed for consent for treatment will be held responsible for cost's incurred during the child's dental treatment. If the guarantor (the party responsible for the account) differs from the party who has signed for consent, please inform the receptionist prior to treatment.

We are happy to file your dental claims to assist you in maximizing your insurance benefits. We will accept the estimated insurance payment directly from your insurance company provided payment is received within 60 days. If your insurance company has not paid the claim within 60 days the balance will automatically be billed to you. Please be aware your insurance is a contract between you, your employer, and the insurance company, therefore we can not guarantee any estimated coverage. We accept no responsibility in the collection of any insurance claims or in the negotiation of any settlement on disputed claims. In the event we receive any overpayment on your account by your insurance company, we will either credit your account or issue a refund. Not all services are covered benefits in all contracts. You are ultimately responsible for the total amount of your dental fees

I have read the above details regarding my financial responsibility towards care rendered at Make A Smile Children's Dental. In consideration of the professional services rendered, I agree to accept responsibility for the payment of such services and I agree to pay all costs and reasonable attorney, interest or late fees incurred by my failure to remit for services rendered. In the event a collection agency is utilized to collect past due balances I have incurred, I agree to pay all collection fees. I understand there is a \$25 charge for any checks returned by the bank and checks will no longer be an acceptable form of payment. I authorize and request my primary and / or secondary insurance company(s) to pay Make A Smile directly. I understand that my dental insurance carrier(s) may pay less than the actual billed services. I authorize Make A Smile to charge my credit card for any payments due. I grant my permission to Make A Smile, or its assignees, to contact me at home or my work to discuss matters related to this form. I have read the above conditions of treatment and agree with the content.

### PAYMENT OPTIONS

For your convenience we provide a variety of payment options to help your child receive the quality care needed to enjoy a healthy smile. We accept cash, checks, Visa and MasterCard.

My signature indicates that I understand the policies as outlined and any questions I have with regard to office policies have been answered.

Please enter your name above. You will sign the document later in our office.

Signature of Parent / Guardian

Relationship to Patient

Date

My signature indicates that I have reviewed the office policies with the responsible party.

Signature of Staff Member

Date