WELCOME ABOARD

About Your Child!

Childs Name: _____ Nickname: _____

D.O.B: _____ Age: _____ Gender: _____

Address: _____

School: _____ Grade: _____

Hobbies: _____

Previous Dentist: _____ Previous Behavior: _____

Has your child had any injuries to the teeth or jaw? _____

How do you think your child will respond towards the dentist? _____

Who may we thank for referring you? _____

Is tooth brushing supervised? _____ Floss used? _____

Please list any special concerns: _____

Dad's Info

_____

Name:

_____

D.O.B.

_____

Social Security Number

_____

Address (if different)

_____

City State Zip Code

Phone: _____

Mom's Info

_____

Name:

_____

D.O.B.

_____

Social Security Number

_____

_____

Address (if different)

_____

City State Zip Code

Phone: _____

Father's Insurance Information

Mother's Insurance Information

Driver's License Number

Employer

Email

Name of Insurance Carrier

Policy ID Number

Group No

Who is accompanying the child today?

Name:_____ Relation:_____

Do you have legal Custody? Yes / No

Is the child adopted? Yes / No Is the child in a foster home? Yes / No

Parent's Marital Status ( ) Single ( ) Widowed ( ) Married ( ) Divorced ( ) Separated

Emergency Contact

Name: Home Phone: Cell Phone:

Release Signature

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all questions truthfully and to the best of my knowledge.

Consent

I undersigned hereby authorize Doctor to take x-Rays, Study Models, Photographs, or any other diagnostic as deemed appropriate by Doctor to make a through diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy, that may be indicated in connections with (Name of Patient)_____ and further authorize and consent that Doctor choose and employ such assistance as deemed fit. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for dental services provided in this office for my dependents is mine, due and payable at the time services are rendered unless financial arrangements have been made. I further understand that a 1.5% finance charge (18% annually) will be added to any balance over 60 days. In the event of default I (we) promise to pay legal interest on the indebtedness, together which such collection cost and reasonable attorney fees as may be required to effect collections of this note.

Patient Name: _____ Date: _____

Witness: _____

Parent or Responsible Party: _____

Relationship to Patient: _____

Sami Smiles
Pediatric Dentistry
& Orthodontics

MISSED APPOINTMENT AGREEMENT

Trying to accommodate every patient's individual needs and work schedules is difficult and our practice is committed to making sure that you are seen on time for your appointment. We work very hard to stay on schedule so that our patients will not spend time waiting for an appointment.

A scheduled appointment is a commitment of time between you and our practice. We have reserved that time exclusively to provide the recommended treatment just for you. When appointments are missed or cancelled, that time is permanently lost.

We ask that when you schedule an appointment that you make every effort to keep that commitment. We understand that personal emergencies sometimes occur, and we always take that into consideration when receiving a last minute cancellation.

If you find that you cannot keep your scheduled appointment, we ask you to provide a minimum of forty-eight hours (48) notice to us so we may schedule another patient in need of treatment. For your convenience, we have an appointment administrator available Monday through Thursday 8:00-5:00pm and Fridays, 8:00 – 3:00pm.

It is our policy that if you have to cancel an appointment with less than forty-eight hours notice a charge of $40 will be applied to your account. If you have any questions regarding this policy please do not hesitate to contact us. We sincerely appreciate your understanding and cooperation with this matter.

_____
Patient Name

_____
Parent Signature

_____
Date

samismilesdental@gmail.com

Patient Name:_____

Patient's Physician's Name:_____Telephone:_____

Physician's Address:_____

Medical History

YES/NO Is your child presently under the care of a physician for any medical problem?
If yes, what for?_____

YES/NO Is your child currently taking any medication?
If yes, what?_____For what?_____

YES/NO Is your child allergic to any food, medicine, or LATEX?
If yes, what?_____

Date of last visit to pediatrician:_____

Does your child now have or has your child ever had a history of any of the following:

- ☐ Heart murmur, Defect, or Heart Surgery
- ☐ Heart attack, angina
- ☐ High Blood pressure, stroke
- ☐ Asthma, or other lung disease
- ☐ Tuberculosis (TB), Emphysema
- ☐ Hepatitis, or other liver disease
- ☐ Sickle Cell Anemia or Trait
- ☐ Hemophilia, or Other Bleeding Disorder
- ☐ Venereal Disease, Herpes
- ☐ Diabetes
- ☐ Kidney Disease
- ☐ Immunocompromised Condition: (Organ Transplant, HIV, AIDS)
- ☐ Joint Surgery (Hip, Knee, Other)
- ☐ Cancer, Tumor or Leukemia
- ☐ Radiation or Chemotherapy
- ☐ Seizures, Epilepsy or Fainting
- ☐ Development delay, Cerebral Palsy
- ☐ Autism, or emotional problems
- ☐ Juvenile Rheumatoid Arthritis
- ☐ Eye Problems, Glaucoma
- ☐ Anemia
- ☐ Allergy to Latex
- ☐ Addicted to drugs
- ☐ Pregnancy

Is there anything of importance in your child's medical history that has not been asked about, or anything else that you think we should know about your child: If so, what?_____

I hereby certify that I have answered every question completely and accurately.

_____ _____
Siganature-Parent or Guardian Date

FOR OFFICE USE ONLY

PATIENT RESUME:

HOSPITALIZATIONS:

SURGERIES:

MEDICATIONS:

ALLERGIES:

MEDICAL ALERT:

DENTIST SIGNATURE:_____DATE:_____