YOUNG SMILES DENTISTRY for kids

Powder Springs/Jonesboro-Hampton Area

Welcome to our Practice!

PATIENT INFORMATION

Today's Date: _____

Patient's Full Name: _____ Name child goes by: _____

Address: _____

Street, City, State, Zip

Home Phone: _____ Cell Phone: _____ Email Address: _____

Patient's Date of Birth: _____ Age: ____ Sex: ___M ___F School: _____ Grade: ___

Name and ages of other children in family: _____

What is the reason for your child's visit? _____

If patient is a minor, parent or guardian names: _____

Whom may we thank for referring you to our office? _____

PARENT & RESPONSIBLE PARTY INFORMATION

Mother's Name: _____ Date of Birth: _____ SSN: ____-___-____

Address: _____

Street, City, State, Zip

Marital Status: _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Employer: _____ #Yrs. _____

Father's Name: _____ Date of Birth: _____ SSN: ____-___-____

Address: _____

Street, City, State, Zip

Marital Status: _____ Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email: _____

Employer: _____ #Yrs. _____

With whom does the patient live: _____ Person financially responsible: _____

PRIMARY INSURANCE INFORMATION

Insured's Full Name: _____ Insured's SSN: ____-___-____

Insurance Co. _____ Group/Policy # _____ Phone: _____

Insurance Co Address: _____ Insured's Birth Date: _____

Insured's Employer: _____ Insured's Employer Phone: _____

SECONDARY INSURANCE INFORMATION (if applicable)

Insured's Full Name: _____ Insured's SSN: ____-___-____

Insurance Co. _____ Group/Policy # _____ Phone: _____

Insurance Co Address: _____ Insured's Birth Date: _____

Insured's Employer: _____ Insured's Employer Phone: _____

Please note by signing this document with your typed/electronic signature, you acknowledge that it holds the same value as your handwritten signature.

Patient's Last & First Name: _____, _____ Date of Birth: _____

EMERGENCY INFORMATION

Name of Emergency Contact person: _____ Phone: _____

Address: _____

Street, City, State, Zip

Parent's Signature (if a minor): _____

MEDICAL HISTORY

Physician: _____ Date of last visit: _____ Phone: _____

Name of Practice: _____ Address: _____

PLEASE CHECK Yes or No (If Yes, please fill in details.)

___Yes ___No Is your child in good health? Date of last Physical Exam: _____

___Yes ___No Has your child ever had a health problem? _____

___Yes ___No Has your child ever been hospitalize or had any major operations? If Yes, please give reason and date/s:

_____

___Yes ___No Were there any problems at birth? If Yes, please explain:

___Yes ___No Is your child taking any medications? If Yes, please give medication name, dose and reason:

___Yes ___No Is your child allergic to any medications? _____

___Yes ___No Does your child have a history of a major illness? _____

___Yes ___No Has your child had any major operations? _____

___Yes ___No Has your child ever been involved in a serious accident? _____

PLEASE MARK if your child has or has been treated for any of the medical conditions/ health issues and elaborate below:

___Abnormal Bleeding
___ADD/ADHD
___Adverse Drug Reactions
___Allergies
___Anemia
___Arthritis
___Asthma/Hay Fever
___Autism
___Bleeding/Transfusions
___Blood Disorder
___Bone Disorders
___Bronchitis
___Cancer/Tumor
___Cerebral Palsy
___Cleft lip/palate
___Congenital Heart Defect
___Diabetes
___Dizziness
___Endocrine/Growth
___Epilepsy
___Eyesight: Blindness/Low Vision
___Frequent Infections
___GI Disorders
___Heart Conditions
___Hepatitis
___Heart Disease
___Heart Murmur
___HIV/Aids
___High Blood Pressure
___Kidney Problems/Disease
___Herpes
___Latex Allergies
___Liver Problems
___Mental Delays
___Neuromuscular Disorder
___Nervous Problems
___Personality/Social
___Physical Delays
___Pneumonia
___Recurrent Headaches
___Rheumatic Fever
___Prolonged Bleeding
___Radiation/Chemotherapy
___Seizures
___Sickle Cell Disease/Trait
___Significant Injuries
___Speech/Hearing
___Tonsils/Adenoids Removed
___Tuberculosis
___Up-to-date on Immunizations

Details on any checked item:

Are there any other medical conditions not listed that we should be aware of?

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Patient's Last & First Name: _____, _____ **Date of Birth:** _____

DENTAL HISTORY

Dentist: _____ Date of last visit: _____
Phone: _____ Address: _____

PLEASE CHECK Yes or No (If Yes, please fill in details.)
___Yes ___No Has your child ever been to the dentist?
Date of last x-rays (if taken): _____
Name of Dentist: _____ Date: _____
___Yes ___No Has your child experienced any unfavorable reaction from previous dental care?
___Yes ___No Does your child suck a finger, thumb, or pacifier?
___Yes ___No Does your child have pain with chewing, yawning, or wide opening of his/her mouth?
___Yes ___No Does your child's jaw make noise and is pain associated with the sounds?
What concerns you most about your child's teeth? _____
___Yes ___No Is your child presently experiencing any dental pain? Explain:

___Yes ___No Has your child ever lost or chipped any teeth? _____
___Yes ___No Has there been any injuries to the child's mouth or teeth face? _____
___Yes ___No Is any part of your child's mouth sensitive to temperature or pressure? _____
___Yes ___No Does your child's gums bleed when your brush? _____
___Yes ___No Does your child have any type of thumb or tongue habit? _____
___Yes ___No Is your child a mouth breather? _____
___Yes ___No Has your child ever seen an orthodontist? _____
___Yes ___No Has anyone in the family received orthodontic treatment? _____
How did they feel about their result? _____
What is your attitude towards receiving orthodontic treatment? _____

AUTHORIZATION & RELEASE

- I have read and answered the above questions to the best of my knowledge.
- I authorize my insurance company to pay Young Smiles Dentistry for Kids all insurance benefits otherwise payable to me for services rendered.
- I authorize the use of this signature on all insurance submissions.
- I authorize Young Smiles Dentistry for Kids to release all information necessary to secure the payment of benefits.
- I understand that I am financially responsible for all charges whether or not paid by insurance. If my account is 90 DAYS past due, my account will be turned over to collections in an effort to collect the remaining balance owed. The collection agency will charge me a fee of 35% to collect this outstanding balance.

Signature of Patient or Responsible Party: _____ Date: _____

PARENTAL PERMISSION TO CONSENT

Please provide the names of any persons whom you consent to bring your child to dental appointments. Keep in mind that this person will be able to consent for treatment and will be financially responsible for any payments on that day of service.

Signature of Patient or Responsible Party: _____ Date: _____

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Patient's Last & First Name: _____, _____ Date of Birth: _____

CONFIRMATION/CANCELLATION POLICY

Due to our high volume of patients and previous appointment conflicts, we have implemented a confirmation policy. To ensure your child is seen in a timely manner, we require you to confirm all appointments 24 hours in advance. This ensures your child's appointment. We will attempt to reach you at all phone numbers you have provided. If our attempt is unsuccessful, **it is your responsibility to confirm your child's appointment.** APPOINTMENTS NOT CONFIRMED MAY BE CANCELLED AT THE DOCTOR'S DISCRETION!

We understand that unforeseen situations can occur. To assist in communication during these times, there are two different ways for you to confirm your appointment.

If you do not confirm your appointment, but arrive **on time** for the scheduled appointment, we will make every attempt to see your child. Please understand this is a courtesy; your child's appointment may have been moved so that another child may be seen. Though we do try to accommodate you, there are times we may have to reschedule. Again, confirmation does ensure your child's appointment and ensures that all patients are seen in a timely manner.

PLEASE NOTE: A 24-hour advanced notice is required in order to cancel a reserved appointment. **Hygiene** broken appointment fee is **$25.00** and **Treatment** broken appointment fee is **$50.00**.

I also understand that it is my responsibility to inform the front office of any change in my contact numbers and/or my mailing address.

_____ _____

Parent or Guardian Signature Date

PHOTO &VIDEO RELEASE

I hereby give permission for images of my child captured during any/all Young Smiles Dentistry for Kids visits or activities of events through video, photo and digital camera, to be used solely for the purposes of Young Smiles Dentistry for Kids; promotional material and publications and waive any rights of compensation or ownership thereto.

Name of Participant (Please print.): _____ Age: _____

Name of Parent/Guardian (Please Print): _____

Signature of Patient or Responsible Party: _____ Date: _____

HIPPA PRIVACY PRACTICE ACKNOWLEDGEMENT

You May Refuse to Sign This Acknowledgement

I, _____ have received a copy of this office's Notice of Privacy Practices and I have been provided an opportunity to review it.

_____ _____

Signature Date

_____

Please Print Name

For Office Use Only

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
- ☐ Communications barriers prohibited obtaining acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

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