THE SMILE INSTITUTE

PATIENT INFORMATION

Patient Name _____ SSN _____ Date _____
LAST FIRST MI

Birth Date _____ Gender [M] [F] Email _____

Address _____
STREET APT #

_____
CITY STATE ZIP CODE

Phone (Home) _____ (Work) _____ Ext. _____ Cell / Other _____

Emergency Contact _____
NAME RELATIONSHIP PHONE NUMBER

RESPONSIBLE PARTY INFORMATION

Name _____ SSN _____ Birth Date _____
LAST FIRST

Gender [M] [F] ☐ Married ☐ Single ☐ Child ☐ Other _____

Address _____
STREET APT #

_____
CITY STATE ZIP CODE

Phone (Home) _____ (Work) _____ (Cell) _____ Best time to call _____

INSURANCE INFORMATION

PRIMARY INSURANCE CARRIER

Name of Insured _____ SSN _____
LAST FIRST MI

Insured's Birth Date _____ ID # _____ Group # _____

Insured's Address _____
STREET APT #

_____
CITY STATE ZIP CODE

Insured's Employer Name & Address _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name & Address _____

SECONDARY INSURANCE CARRIER

Name of Insured _____ SSN _____
LAST FIRST MI

Insured's Birth Date _____ ID # _____ Group # _____

Insured's Address _____
STREET APT #

_____
CITY STATE ZIP CODE

Insured's Employer Name & Address _____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name & Address _____

Patient Name: _____

MEDICAL HISTORY

1) Was your child premature?

_____

2) Were there any difficulties during the pregnancy, delivery, or first year of life? ☐ Yes ☐ No

a) Please explain

_____

3) Is a physician treating your child now for a specific illness? ☐ Yes ☐ No

a) Please explain

_____

4) Is your child taking any medications at this time? ☐ Yes ☐ No

DRUG	DOSE	FREQUENCY	REASON

5) Has your child taken any medications in the past? ☐ Yes ☐ No Please explain:

_____

6) Has your child had any allergies or unusual reactions to the following?

a) Medications ☐ Yes ☐ No Foods ☐ Yes ☐ No Latex ☐ Yes ☐ No

b) Other ☐ Yes ☐ No Please explain:

_____

7) Has your child ever been hospitalized? ☐ Yes ☐ No Please explain:

_____

8) Has your child ever had an operation? ☐ Yes ☐ No

a) Please explain

_____

b) Was general anesthesia used? ☐ Yes ☐ No

i) Any complications? Please explain ☐ Yes ☐ No

_____

9) Are your child's immunizations up-to-date? ☐ Yes ☐ No

Please Complete Other Side >>

Patient Name: _____

10) Has your child ever been diagnosed with any of the following conditions? Please check **yes or no.**

Yes	No		Yes	No		Yes	No	
		Anemia			Congenital heart disease			Kidney disease
		Asthma			Convulsions			Leukemia
		Autism			Diabetes			Mental retardation
		Bladder Conditions			Emotional disturbances			Nutritional deficiency
		Blood Transfusions			Epilepsy			Oral ulcers
		Birth Defects			Eye problems			Orthopedic problems
		Bone or joint problems			Excessive bleeding problems			Premature birth
		Brain injury			Excessive gagging			Rheumatic fever
		Bruising easily			Fainting or dizziness			Scoliosis
		Cancer or malignancies			Growth and Development Problems			Sickle cell anemia
		Cerebral palsy			Hearing/speech problems			Syndrome
		Child abuse			HIV			Tuberculosis
		Chronic adenoid/tonsil			Heart murmur			Other
		Chronic headaches			Hemophilia			
		Chronic ear infections			Hepatitis or liver disease			
		Cleft lip/palate			Hyperactivity			

DENTAL HISTORY

1) Please check reason(s) for seeking dental care

☐ First Examination ☐ Routine Check-up ☐ Toothache or swelling

☐ Appearance of teeth ☐ Crowding of teeth ☐ Accident

Other:_____

2) Has your child been to a dentist previously? ☐ Yes ☐ No

a) When was the last visit

_____

b) Have x-rays been taken? ☐ Yes ☐ No When?

_____

c) How would you describe your child's temperament?

☐ Outgoing ☐ Shy ☐ Stubborn ☐ Anxious ☐ Frightened ☐ Regular Kid

☐ Curious ☐ Moody ☐ Friendly ☐ Defiant ☐ High Strung ☐ Cooperative

Please Complete Other Side >>

Patient Name: _____

3) How do you think your child will react to dental treatment?

_____

4) Is a physician treating your child now for a specific illness? ☐ Yes ☐ No Please explain:

_____

5) Does your child have fluoride in any of the following forms?

a) Toothpaste ☐ Yes ☐ No Brand _____

b) Drinking Water ☐ Yes ☐ No

c) Topical Application ☐ Yes ☐ No

d) Fluoride Tablets ☐ Yes ☐ No (**0.25 mg / 0.5 mg / 1.0 mg)**

6) Does your child brush his/her **own** teeth? ☐ Yes ☐ No

a) When? ☐ AM ☐ PM ☐ After Snacks ☐ Before Bed ☐ After Breakfast

7) Do **you** brush your child's teeth? ☐ Yes ☐ No

a) When? ☐ AM ☐ PM ☐ After Snacks ☐ Before Bed ☐ After Breakfast

8) Do **you** or **your child** use dental floss in cleaning your child's teeth? ☐ Yes ☐ No

a) When? ☐ AM ☐ PM ☐ After Snacks ☐ Before Bed ☐ After Breakfast

9) Does your child have snacks in between meals? ☐ Yes ☐ No

a) If yes, please describe the snacks

_____

10) Have your child's teeth ever been injured? ☐ Yes ☐ No

a) If yes, please explain when, how, where, and how it was managed

_____

11) Does your child have any of the following habits?

☐ Thumb or finger sucking ☐ Lip sucking or biting ☐ Bottle to bed at night

☐ Pacifier ☐ Mouth breathing

I hereby give permission to The Smile Institute to provide dental treatment to my child, which the doctor deems necessary and appropriate. Routine treatment may include, but not limited to, topical and local anesthetic (injections), radiographs, etc.

Who can we thank for your referral?_____

Name of child _____

Signature of legal guardian _____ Date _____

THE SMILE INSTITUTE

FINANCIAL POLICY

Thank you for choosing The Smile Institute to meet your dental needs. Our goal is to create a relaxed environment where we provide comprehensive dental care by leading edge practitioners who not only practice dentistry, but also teach and are involved in research to improve oral health.

Non-insured Patients:

Payment in full is required at the time of service. However, we will make payment arrangements for major procedures. These arrangements must be made **before** treatment is started.

Insured Patients:

We accept most dental plans but It is your responsibility to know your benefits and coverage, including yearly maximums, waiting periods, and any other coverage exceptions or limitations. However, we will contact your insurance carrier to verify your benefits and determine your estimated coverage. This is usually a rough estimate because the insurance company does not have to reveal the maximum fee it will reimburse for services, generally referred to as the UCR or the usual and customary rate/fee. As a courtesy, we will file your claim and require that the benefits be assigned directly to our office. We expect you to pay the uncovered portion of your services the day your services are rendered. If your insurance carrier has not paid their portion within 60 days you are immediately responsible for the balance in full. **You are responsible for any amount your insurance does not pay.**

All Patients:

Our fees are subject to change. Any outstanding balance not paid at the time services are rendered, will be turned over to our collection agency after 60 days. The patient or person responsible for the account agrees to pay any administrative fees, attorney fees, court costs, or any other costs of collection. Accounts sent to our collection agency are subject to a 15% Collection and/or Attorney Fee. Any accounts having a balance over 45 days past due will be assessed an interest of 12% APR.

Cancellation and Rescheduling policy

Please be advised that we require 24-hour notice be given to reschedule or cancel appointments. If 24-hour notice is not given, you may be subject to a $50 per appointed hour charge. We confirm appointments within two days to one week of your appointment, depending on your dental service type. We request a call back for confirmation of scheduled appointments.

I have read this financial policy and accept the content.

Please Print Name: _____

_____ _____

Patient/Responsible Party Signature Date