

**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 \_\_\_\_\_

**MEDICAL HISTORY**

 1) Was your child premature?
 

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

 a) Please explain
 

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

 a) Please explain
 

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 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:
 

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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:
 

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

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

 a) Please explain
 

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 b) Was general anesthesia used?  Yes  No

 i) Any complications? Please explain  Yes  No
 

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

**Please Complete Other Side >>**

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? \_\_\_\_\_

**Please Complete Other Side >>**

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

- |                                   |                                |                                   |                                  |                                      |                                      |
|-----------------------------------|--------------------------------|-----------------------------------|----------------------------------|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Outgoing | <input type="checkbox"/> Shy   | <input type="checkbox"/> Stubborn | <input type="checkbox"/> Anxious | <input type="checkbox"/> Frightened  | <input type="checkbox"/> Regular Kid |
| <input type="checkbox"/> Curious  | <input type="checkbox"/> Moody | <input type="checkbox"/> Friendly | <input type="checkbox"/> Defiant | <input type="checkbox"/> High Strung | <input type="checkbox"/> Cooperative |

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

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

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

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Thumb or finger sucking | <input type="checkbox"/> Lip sucking or biting | <input type="checkbox"/> Bottle to bed at night |
| <input type="checkbox"/> Pacifier                | <input type="checkbox"/> 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 \_\_\_\_\_

Signature of Doctor \_\_\_\_\_ Date \_\_\_\_\_



## 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