Patient In-take Form—Child

PATIENT INFORMATION (PRINT PLEASE)

Child's name: Gender: ☐ Male ☐ Female Date: / /

Address:

City: State: ZIP:

Date of birth: ( ) Phone: / / Social Sec. #:

School: Grade:

How did you hear about our dental office? ☐ Friend/family ☐ Ad ☐ Internet ☐ Other:

Has your child ever been seen by **HELP A CHILD SMILE DENTAL PROGRAM**? ☐ Yes ☐ No

MOTHER

Name:

Home phone: ( ) Work phone: ( )

Employer's name:

Social Sec. #: Date of birth: / /

FATHER

Name:

Home phone: ( ) Work phone: ( )

Employer's name:

Social Sec. #: Date of birth: / /

HEALTH HISTORY

How many times per day does your child brush? Is your child's water fluoridated? ☐ Yes ☐ No

Previous dentist: Date of last visit: / /

List any medications your child is currently taking:

Is your child allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex ☐ Local anesthetics

☐ Other If yes, please explain:

Is your child currently under the care of a physician? ☐ Yes ☐ No Child's physician:

Is your child pregnant? ☐ Yes ☐ No If yes, due date: / /

Additional comments:

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DOES YOUR CHILD HAVE, OR HAVE THEY EVER HAD, ANY OF THE FOLLOWING?

AIDS/HIV Positive	☐ Yes ☐ No	Cortisone Medicine	☐ Yes ☐ No	Hemophilia	☐ Yes ☐ No	Renal Dialysis	☐ Yes ☐ No
Alzheimer's Disease	☐ Yes ☐ No	Diabetes	☐ Yes ☐ No	Hepatitis A	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Anaphylaxis	☐ Yes ☐ No	Drug Addiction	☐ Yes ☐ No	Hepatitis B or C	☐ Yes ☐ No	Rheumatism	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Easily Winded	☐ Yes ☐ No	Herpes	☐ Yes ☐ No	Scarlet Fever	☐ Yes ☐ No
Angina	☐ Yes ☐ No	Emphysema	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No	Shingles	☐ Yes ☐ No
Arthritis/Gout	☐ Yes ☐ No	Epilepsy or Seizures	☐ Yes ☐ No	Hives or Rash	☐ Yes ☐ No	Sickle Cell Disease	☐ Yes ☐ No
Artificial Heart Valve	☐ Yes ☐ No	Excessive Bleeding	☐ Yes ☐ No	Hypoglycemia	☐ Yes ☐ No	Sinus Trouble	☐ Yes ☐ No
Artificial Joint	☐ Yes ☐ No	Excessive Thirst	☐ Yes ☐ No	Irregular Heartbeat	☐ Yes ☐ No	Spina Bifida	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Fainting Spells/Dizziness	☐ Yes ☐ No	Kidney Problems	☐ Yes ☐ No	Stomach/	
Blood Disease	☐ Yes ☐ No	Frequent Cough	☐ Yes ☐ No	Leukemia	☐ Yes ☐ No	Intestinal Disease	☐ Yes ☐ No
Blood Transfusion	☐ Yes ☐ No	Frequent Diarrhea	☐ Yes ☐ No	Liver Disease	☐ Yes ☐ No	Stroke	☐ Yes ☐ No
Breathing Problem	☐ Yes ☐ No	Frequent Headaches	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No	Swelling of Limbs	☐ Yes ☐ No
Bruise Easily	☐ Yes ☐ No	Genital Herpes	☐ Yes ☐ No	Lung Disease	☐ Yes ☐ No	Thyroid Disease	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Glaucoma	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No	Tonsillitis	☐ Yes ☐ No
Chemotherapy	☐ Yes ☐ No	Hay Fever	☐ Yes ☐ No	Pain in Jaw Joints	☐ Yes ☐ No	Tuberculosis	☐ Yes ☐ No
Chest Pains	☐ Yes ☐ No	Heart Attack/Failure	☐ Yes ☐ No	Parathyroid Disease	☐ Yes ☐ No	Tumors or Growths	☐ Yes ☐ No
Cold Sores/Fever Blister	☐ Yes ☐ No	Heart Murmur	☐ Yes ☐ No	Psychiatric Care	☐ Yes ☐ No	Ulcers	☐ Yes ☐ No
Congenital Heart Disorder	☐ Yes ☐ No	Heart Pace Maker	☐ Yes ☐ No	Radiation Treatments	☐ Yes ☐ No	Venereal Disease	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	Heart Trouble/Disease	☐ Yes ☐ No	Recent Weight Loss	☐ Yes ☐ No	Yellow Jaundice	☐ Yes ☐ No

Has your child ever had any serious illness not listed above? ☐ Yes ☐ No If yes, please explain:_____

DENTAL INSURANCE INFORMATION

Primary Ins. Company: Group #:

Address: Phone: ( )

City: State: ZIP:

Insured's name: Social Sec. #:

Insured's employer: Date of birth: / /

Employer's address:

City: State: ZIP:

AGREEMENT AND AUTHORIZATION

I give the Smile Dental Group of Conyers, PC permission to treat my child with cleaning, X-rays, sealants, fluoride treatments and if cavities are found, to treat these (including permission to use local anesthesia to numb for the patient's comfort, if necessary.)

I understand that keeping appointments is very important. If I cannot make an appointment, for any reason, I must give at least 24 hours notice. Failure to provide 24 hours notice for a missed appointment may prevent me from being able to reserve future appointments in advance.

I understand that my health insurance carrier may pay less than the actual bill for services rendered on my/my dependents' behalf, and that I am responsible for the difference. If I do not pay my entire new balance within 25 days of the monthly billing date, a late charge of 1.5% on the balance then unpaid and owed will be assessed each month. I realize that failure to keep this account current may result in Smile Dental Group being unable to provide additional services. In the case of default on payment of this account, I agree to pay collection costs and reasonable attorney fees (usually 40% of the amount owed) incurred in attempting to collect on this account balance.

I certify that I have read and understand the above information to the best of my knowledge. I understand that providing incorrect information can be dangerous to my health. I give Smile Dental Group permission to perform dental treatments on me/my child, which may include anesthesia for the patient's comfort. I authorize Smile Dental Group to leave messages on my home answering machine or cell phone voice mail concerning appointment times, scheduled treatment including premedication reminders, and payment information.

I authorize Smile Dental Group to use or disclose any necessary patient health information (PHI) in order to carry out treatment, payment activities, and health care operations, as fully described in our Notice of Privacy Practices. I understand that upon request I will receive a copy of the Notice of Privacy Policies as prescribed by the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

_____ _____

Signature of patient (or parent if a minor) Today's date