TENDER SMILES 4 KIDS

PATIENT INFORMATION

Patient Name:_____**BIRTH DATE**_____
First Last
____**Male** _____**Female** **School**_____**Grade**_____
Home Address:_____
Street Apt #
_____
City State Zip Code

PARENT OR RESPONSIBLE PARTY INFORMATION

Father/Guardian:_____**e-mail**_____
Social Security#_____**Birth Date:**_____
Telephone
(Home)_____**(Work)**_____**(Cell)**_____

Employer Name:_____**Occupation:**_____

Work Address:_____
Street City State Zip Code
Mother/Guardian:_____**e-mail**_____
Social Security#_____**Birth Date:**_____
Telephone
(Home)_____**(Work)**_____**(Cell)**_____

Employer Name:_____**Occupation:**_____

Work Address:_____
Street City State Zip Code

INSURANCE INFORMATION

Primary Insurance
Name of Insured:_____**ID#**_____
Insurance
Co.:_____**Group#**_____
Address:_____
Secondary Insurance
Name of Insured:_____**ID#**_____
Insurance Co:_____**Group#**_____
Address:_____

REFERRAL INFORMATION

How did you find out about our office? _____

EMERGENCY CONTACT

In case of an emergency, other than parent or guardian, who should we contact?
Name_____**Phone #**_____
Relationship to Patient_____

CHILD'S HEALTH HISTORY

Physician's Name_____
Address Phone

Has your child ever had any of the following?

___AIDS/HIV
___Allergies_____
_____
___Anemia
___Autism
___Asthma
___Blood Disease
___Cancer
___Diabetes
___Dizziness
___Epilepsy
___Excessive Bleeding
___Fainting
___Hay Fever
___Head Injuries
___Heart Disease
___Heart Murmur
___Hepatitis
___High Blood Pressure
___Jaundice
___Kidney Disease
___Liver disease
___Liver Disease
___Mental Disorder
___Nervous Disorder
___Penicillin Allergy
___Respiratory Problems
___Rheumatic Fever
___Sinus Problems
___Stomach Problems
___Tuberculosis
___Other _____

Has your child ever been admitted to a hospital or needed emergency care? ___Yes ___No
If yes, please explain:_____

Is your child now under the care of a physician?___Yes ___No Medications:_____
If yes, please explain:_____

Is this your child's first visit to the dentist? ___Yes ___No
If no, child's previous dentist_____
What was done previously (restorations, cleaning, x-rays)?_____
Has your child ever had a toothache? ___Yes ___No
If yes, when? ___while eating ___at night ___spontaneous ___ persistent
Has your child ever bumped his/her teeth? ___Yes ___No
Does your child suck a thumb or finger, pacifier or have any similar habits? ___Yes ___No
Is your water supply fluoridated or is your child taking supplemental fluoride? ___Yes ___No
At what age was bottle/breast feeding stopped?_____
How many times a day are your child's teeth brushed?_____ Adult supervision?___Yes ___No
Flossing? ___Yes ___No Does your child swallow toothpaste?___Yes __No
Is your child apprehensive about visiting the dentist? ___Yes ___No
Reason for today's visit_____

CONSENT FOR SERVICES

Tender Smiles 4 Kids follows Federal & State law by complying with HIPPA standards. Our Notice of Privacy Practices took effect on April 15, 2003 and is available upon your request.

As a condition of your treatment by this office, financial arrangements must be made in advance. All emergency dental services, or any dental service performed without previous financial arrangements must be paid in full at the time services are rendered. Patients who carry dental insurance understand that all dental services furnished may be charged directly to the insurance company and that he or she is personally responsible for payment of all dental services not covered by said insurance company. A service charge of 1 ½ % (18% per annum) on the unpaid balances will be charged on all accounts exceeding 60 days , unless previous written financial arrangements are satisfied.

APPOINTMENT POLICY: PLEASE NOTIFY THIS OFFICE 24 HOURS PRIOR TO AN APPOINTMENT IF YOU MUST CANCEL IT. THIS OFFICE RESERVES THE RIGHT TO CHARGE A CANCELLATION FEE.

I certify that I have read and understand the above. I understand the information that I have given is correct to the best of my knowledge. I will not hold Tender Smiles 4 Kids or any member of the staff responsible for any errors or omissions that I may have made in the completion of this form. I also authorize the Doctors and the dental staff to perform the necessary dental services my child may need.

_____
Signature of parent or guardian Date Relationship to child