# Child New Patient Forms

SMILE with STYLE
3261 N. Harbor Blvd. Suite A | Fullerton, CA 92835
714.870.9445 | www.SmileWithStyle.com

## 1. About Your Child

Date: _____

Name: _____
Last First MI

Nickname: _____

Sex: ❍Male ❍Female

Birthdate: _____/_____/_____

Email: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____

Special interests, sports or hobbies: _____

_____

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

_____

## 2. Responsible Party Information

Name: ❍Mr. ❍Mrs. ❍Ms. ❍Dr.

_____
Last First MI

Sex: ❍Male ❍Female Birthdate: _____/_____/_____

Social Security #: _____-_____-_____

Relationship to Child: _____

Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Employer: _____

Employer Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____

Cell Phone: (_____)_____

Work Phone: (_____)_____ ext: _____

Person to contact in an emergency: _____

Other Parent: ❍Mr. ❍Mrs. ❍Ms. ❍Dr.

_____
Last First MI

Sex: ❍Male ❍Female

Birthdate: _____/_____/_____

Social Security #: _____-_____-_____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____)_____

Cell Phone: (_____)_____

Work Phone: (_____)_____ ext: _____

## 3. Dental Insurance #1

Insured's Name: _____
Last First MI

Insured's Birthdate: _____/_____/_____

Insured's Social Security #: _____-_____-_____

Insured's Employer: _____

Ins. Company: _____

Ins. Co. Phone: (_____)_____ ext: _____

Ins. Address: _____

City: _____ State: _____ Zip: _____

Ins. ID No. _____

Ins. Group No. _____

## 4. Dental Insurance #2

Insured's Name: _____

Insured's Birthdate: _____/_____/_____

Insured's Social Security #: _____-_____-_____

Insured's Employer: _____

Ins. Company: _____

Ins. Co. Phone: (_____)_____ ext: _____

Ins. Address: _____

City: _____ State: _____ Zip: _____

Ins. ID No. _____

Ins. Group No. _____

## 5. Child's Medical History

Is your child currently under the care of a physician? Y / N

Please explain: _____

_____

_____

Physician's Name: _____

Phone: (_____)_____

Date of last visit to physician: _____/_____
mo year

Your child's current physical health is: ❍Good ❍Fair ❍Poor

Does your child take any medication, drugs or pills? Y / N

Please list each one: _____

_____

_____

## 5. Child's Medical History Cont.

Has your child ever had any of the following? Please circle your answer for each line:

Y / N Asthma
Y / N Bleeding Issues
Y / N Cancer
Y / N Convulsions
Y / N Diabetes
Y / N Epilepsy
Y / N Hearing Impairment
Y / N Heart Conditions
Y / N Heart Murmur
Y / N HIV/AIDS
Y / N Hospitalization
Y / N Hyperactivity
Y / N Nervousness
Y / N Rheumatic Fever
Y / N Scarlet Fever
Y / N Tuberculosis (TB)

Please list any other serious medical condition(s) that your child has/had: _____

_____

_____

Has a physician ever informed you that your child needed premedication w/ an antibiotic prior to dental treatment? Y / N

Is your child allergic to any of the following?

Y / N Aspirin, Ibuprofen, Tylenol
Y / N Codeine
Y / N Dental Anesthetics
Y / N Erythromycin
Y / N Latex
Y / N Penicillin/Amox
Y / N Tetracycline
Y / N Metals, Fluoride, etc.

Please list any other drugs or substances that your child has reacted adversely to: _____

_____

_____

## 6. Dental History

Why has your child come to Smile with Style today? _____

_____

_____

Previous Dentist Name: _____

Phone: (_____)_____

Date of last dental visit: _____/_____ (mo / year)

Date of last dental x-rays: _____/_____ (mo / year)

Reason for leaving previous dental office *(optional)*: _____

_____

- Is your child currently in pain? Y / N
- Has your child ever had a serious/difficult problem associated with any previous dental work? Y / N
- Does your child grind or clench his/her teeth? Y / N
- Your child's current dental health is: ❍Good ❍Fair ❍Poor
- How many times a day does your child brush? _____
- Type of bristle? ❍Soft ❍Medium ❍Hard
- How many times do they floss a day? _____
- Does your child play any sports that require a mouthguard? Y / N
- Are your child's teeth sensitive to hot, cold or anything else? _____

  _____

  _____
- Is there anything we can do to make your child's visit even more enjoyable? _____

  _____

  _____

*All medical history information will be kept confidential. I understand that the information I have given today is correct to the best of my knowledge. It is my responsibility to inform this office of any changes in my medical status or if I start a new medication.*

**Parent Signature:** _____ **Date:** _____

**FOR OFFICE USE ONLY**

Blood Pressure: _____
Pulse Rate: _____/ minute
Date: _____

*Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.*

I verbally reviewed the medical/dental information above with the patient named herein.

| Initials/Date | Initials/Date | Initials/Date | Initials/Date |
|---|---|---|---|
| _____/_____ | _____/_____ | _____/_____ | _____/_____ |
| _____/_____ | _____/_____ | _____/_____ | _____/_____ |
| _____/_____ | _____/_____ | _____/_____ | _____/_____ |
| _____/_____ | _____/_____ | _____/_____ | _____/_____ |

# CONSENT

## TREATMENT

*I authorize **Kirk Larson, D.D.S., Timothy Hedrick, D.D.S. and staff** to take x-rays, study models, photographs, 3D scans or any other diagnostic aids deemed appropriate by the doctors to make a thorough diagnosis of my dental needs. I further authorize the doctors and staff to perform all recommended treatment mutually agreed upon by me and to use the appropriate medication and therapy indicated for such treatment.*

*I acknowledge that the dentist may engage the assistance of other specialists in performing such services, treatments and/or procedures and in utilizing such diagnostic methods.*

*I understand that the practice of dentisty is not an exact science and that no guarantees have been made to me concerning the results of the services, treatments, procedures and/or diagnostic methods that have been recommended. I also understand that the use of anesthesia carries with it significant risks that have been explained to me.*

## PATIENT CONSENT

*I understand that, under the **Health Insurance Portability & Accountability Act of 1996 (HIPAA),** I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:*

- *conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in my treatment (directly and indirectly)*
- *obtain payment from third-party payers*
- *conduct normal healthcare operations such as quality assessments and physician certifications*

*I have been informed by you of your **Notice of Privacy Practices** containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its **Notice of Privacy Practices** from time to time and that I may contact this office at any time to obtain the most current information.*

*I understand that I may request in writing that you restrict how my private information is used or disclosed in order to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.*

## FINANCIAL

*I acknowledge that I am responsible for the payment of all fees associated with the services, treatments, procedures and/or diagnostic methods performed and utilized by the dentist and others. I acknowledge that any insurance coverage that I have is based on a contract between my insurance company and me, my spouse and/or my employer. The dentist is not party to this contract and the services, treatments, procedures and/or diagnostic methods provided to me. Therefore, I acknowledge that I am fully responsible for the payment of all sums owed to the dentist for the services, treatments, procedures and/or diagnostic methods provided to me.*

## FINANCIAL (continued)

*As a courtesy to me, the dental office will bill my insurance company and I acknowledge that I will remain liable to any and all amounts not paid by the insurance company for any reason (including but not limited to the insurance company declining coverage after initially approving it) or if the insurance company fails for any reason to reimburse the dentist within 30 days after being billed by the dentist. I acknowledge that it is my responsibility to provide the dentist with my current insurance or any changes thereto.*

*I consent to the dentist's use and disclosure of my health information to my insurance company and any agent thereof. I hereby assign to the dentist all of the insurance due to me for the servies, treatments, procedures and/or diagnostic methods provided to me, and I authorize my insurance company to make payment directly to the dentist for the costs associated therewith.*

*I further consent to be contacted by the dentist or any agent of the dental office or any collection agency (or agent thereof) or attorney to whom an unpaid account balance has been assigned or referred (a) by mail at any address that I provide to the dental office and/or (b) at any facsimile number, email address or phone number (whether a cell phone or landline) that I provide to the dental office or any agent of the dental office.*

*I agree to promptly pay all amounts due and I understand that all returned checks will be subject to a $15 return check fee.*

## DELINQUENCY, ACCOUNTS, COLLECTION

*Any account balances that remain unpaid for 90 days from the date of service may be referred to a collection company or an attorney. In the event this occurs, I understand that I will be liable for collection costs. Additionally, in the event any unpaid account balance is referred to an attorney for collection by the dentist or a collection agency, I agree to be responsible for all costs and reasonable attorneys' fees incurred in connection therewith.*

## FAILED APPOINTMENTS

*I agree to give the office at least 2 business days notice if I am unable to keep my appointment. **I agree that after 2 FAILED appointments, I will PREPAY for future visits.***

## PHOTOGRAPHS, VIDEOS, IMAGES

*I acknowledge that photographs, videos, and other images, such as x-rays, 3D scans and other records may be created during my examination, treatment, and follow-up care. By signing below, I give my permission for such items to be used for purposes of reasearch, education, advertisement or publication. Identifying information will be omitted. I also understand that I have a right to refuse to sign this acknowledgement.*

**Patient Name:** _____ **Relationship to Patient (if other than self):** _____

**Responsible Party Signature:** _____ **Date:** _____