Welcome to

Smile Shapers

Family and Cosmetic Dentistry

Child Medical History

ABOUT YOUR CHILD

Child's Name:

Nickname: ☐ Male ☐ Female

Date of Birth: Age: SSN:

Home Address:

Home Phone: ( )

School: Grade:

Siblings Names:

DENTAL HISTORY

What is the primary reason for your visit today?

Who referred you to our office?

Date of last dental visit?

Name of dentist:

	YES	NO
Has child had trouble from previous dental care?	☐	☐
Does child have pain in her/her jaw joint (TMJ)?	☐	☐
Has child ever had Novocaine or other local anesthetic?	☐	☐
Is child taking fluoride supplements?	☐	☐
Does child have bad breath?	☐	☐
Does child have frequent sores on lips or mouth?	☐	☐
Is child experiencing any pain or sensitivity in his/her mouth or teeth?	☐	☐
Are there any other problems not covered in this section that you would like to discuss?	☐	☐

If so, please specify:

Does child have any of the following habits?	YES	NO
Lip sucking / biting	☐	☐
Nail biting	☐	☐
Breathing through mouth	☐	☐
Clenching / grinding teeth	☐	☐
Thumb / finger sucking	☐	☐
Used pacifier	☐	☐
Tongue / cheek biting	☐	☐
Tongue thrust	☐	☐
Breast fed	☐	☐
Frequent bottle use or sleeps with bottle at night	☐	☐

PARENT INFORMATION

Your Name:

Relationship: ☐ Mother ☐ Father ☐ Other:

If other, please specify:

Occupation: Work Phone: ( )

Home Phone: ( ) Cell Phone: ( )

Alternate Contact:

Relationship: ☐ Mother ☐ Father ☐ Other:

Occupation: Work Phone: ( )

Home Phone: ( ) Cell Phone: ( )

Emergency Contact:

Relationship to Child:

Phone: ( ) Cell Phone: ( )

DENTAL INSURANCE INFORMATION

PRIMARY

Insured's Name:

Date of Birth: SSN:

Employer:

Relationship to subscriber:

Insurance Company:

SECONDARY

Insured's Name:

Date of Birth: SSN:

Employer:

Relationship to subscriber:

Insurance Company:

MEDICAL INFORMATION

Child's Physician:

Physician Phone: ( )

Physician Fax: ( )

Physician Address:

Date of Last Exam:

Continued on reverse. Please complete both sides.

MEDICAL HISTORY

Certain illnesses and drugs may have a direct effect on the oral cavity and, consequently, dental treatment. In our endeavor to render appropriate uncompromising health care, it is necessary that **Smile Shapers** has the following information.

Does your child have, or has your child ever, had the following? If so, please indicate "YES" and circle the illness:

	YES	NO
1. Allergies – Medications (i.e., penicillin, etc.) – Food, dust, etc. Specify: ______	☐	☐
2. Anemia or blood disorders?	☐	☐
3. Any abnormal or prolonged bleeding or easily bruised?	☐	☐
4. Asthma or other respiratory ailment?	☐	☐
5. Cancer?	☐	☐
6. Congenital heart disease or heart murmur?	☐	☐
7. Convulsions, seizures, fainting or epilepsy?	☐	☐
8. Diabetes or blood sugar problems?	☐	☐
9. High/low blood pressure?	☐	☐
10. Immunioompromised HIV AIDS?	☐	☐
11. Kidney or bladder problems?	☐	☐
12. Liver or thyroid problems?	☐	☐
13. Rheumatic fever or rheumatic heart disease?	☐	☐
14. Tuberculosis or pneumonia?	☐	☐
15. Speech, learning or hearing disorders?	☐	☐
16. Hospitalized since birth? Specify: ______	☐	☐
17. Presently taking any medications? Specify: ______	☐	☐
18. Childhood illnesses? Specify: ______	☐	☐
19. Any medical conditions/problems not stated above that should be brought to our attention? Specify: ______	☐	☐

ADDITIONAL INFORMATION

Please include any additional medical or dental conditions or concerns not listed above that we should know about:

PARENT OR GUARDIAN SIGNATURE	DATE	DOCTOR SIGNATURE	DATE

I hereby certify that the information provided on this form is true and correct in its entirety. Since ______ (NAME OF CHILD) is a minor patient, signed permission from a parent of guardian is required before any necessary dental treatment can be initiated. By signing this form, I hereby grant such permission.

I also acknowledge my responsibility for any professional fees incurred for dental services provided to the child.

I authorize **Smile Shapers** to release my child's dental records to the insurance carrier(s) named on the reverse side for insurance purposes.

Signed X **Date**

This section is for Dentist use only.

DOCTOR UPDATES

DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS
	X		X		X
DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS
	X		X		X
DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS
	X		X		X
DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS	DATE	DOCTOR INITIALS
	X		X		X

DOCTOR COMMENTS

WL 5868039000/Smile Shapers/09-07

General Dentistry Informed Consent Form

Informed Consent for Dental Treatment of a Minor

Patient's Name: ____________________________________ Patient's Date of Birth:______________________

- I have been informed of the need for my child to undergo dental treatment.
- I have been fully informed about the details of the recommended treatment and alternatives, if any, as well as the advantages, disadvantages and risks of each, and the prognosis if no treatment is provided.
- I understand that my child will receive all or some the following: teeth cleaning, fluoride application, radiographs, fillings, stainless steel crowns, sealants, extractions, pulpotomies, pulpectomies (root canals), local anesthetic, nitrous-oxide, space maintainers, oral sedation, other ______________________________________.
- I understand that as treatment proceeds, there may be the need to change the treatment plan which may result in a change in cists and/or the number of required visits.
- I confirm that I have provided an accurate and complete written health history for my child; including any medications my child is currently taking, as well as those which he or she is allergic to.
- I understand that individual reactions during or following treatment cannot be predicted, and if my experiences any unanticipated reactions during or following treatment, I agree to report them to the office as soon as possible.
- I will follow any and all treatment and post-treatment instructions as explained and directed. I have been told that the success of the recommended treatment depends upon my cooperation in keeping the scheduled appointments, following home care instructions (including, but not limited to, oral hygiene and dietary instructions), and reporting to the office any changes in my child's health status as soon as possible.
- I understand that there may be side effects from dental treatment that may include, but not limited to, the following: infection, pain, swelling, bleeding, numbness, laceration of oral tissues, aspiration or swallowing of objects, and emotional upset.
- For those patients having nitrous-oxide: I understand that nitrous-oxide is going to be used on my child. I have been informed that my child will be fully awake, able to speak, understand, and answer questions. Further, I have been informed that it is used to make my child more comfortable and to help allay any fears or anxieties that my child may have. The doctor has told me that any complications, if the occur, can include, but are not limited to, nausea, vomiting, and drowsiness. A heavy meal within two hours of treatment should be avoided.
- I have been informed that my child should not eat chewy or sticky food and that doing so may result in the failure of treatment such as crowns, fillings, sealants and space maintainers.
- I have discussed all of the above with the treating doctor, and all of my questions have been answered. I further acknowledge that no guarantees or assurances have been given by anyone as to the results of the treatment that may be obtained. I realize that in spite of the possible complications and risks, including, but not limited to those described above, my child's recommended treatment is necessary.

Following the explanation, discussion, and the answers to all my questions, I have read and understand this consent form and I authorize the recommended treatment. I agree to pay the charges incurred for my child's treatment.

___________________________________ ____________________________________ ____________________

Signature of Parent/Guardian Relationship to Patient Date

____

Witness

Smile Shapers Dental

Appointment Policy

We require at least 24 hour notice, to make changes to a scheduled appointment. Appointment changes without 24 hours prior notice are subject to a $40 fee. As a courtesy to our patients we confirm appointments 1-2 days prior to your appointment. To assist us in this, please give us a phone number where you can best be reached........

Home # (   ) ____________________________

Cell # (   ) ____________________________

Work # (   ) ____________________________

Email ____________________________________

Please come financially prepared to each appointment. Co-payment is due at date of service.

If you are required by your physician to be pre-medicated prior to dental treatments, please be sure the antibiotic is taken 1 hour prior to your scheduled appointments.

I understand the above stated Smile Shapers policy. In addition I understand that repeated failures to keep appointments without sufficient notice can lead to termination of Doctor-Patient relationship.

X____ ________________________

Signature of Patient Date

Smile Shapers
Family & Cosmetic Dentistry

FINANCIAL POLICY

Our philosophy is to make our patients lives healthier and more comfortable by providing *High Quality, Compassionate Dental Care*.

Smile Shapers Dental is committed to providing you with the best possible dental care. To do this, it is important that we do not allow your dental benefits to be a determining factor in the diagnosis. Your treatment will be based upon your dental needs. We assume that you are as concerned as we are about maintaining your excellent health.

Due to many changes in insurance policies, it is no longer an easy task to interpret each patient's individual policy. Although we try to stay aware of these changes, it is not always possible. Therefore, please be aware that it is the patient's responsibility to know your coverage. Failure to comply with this suggestion could result in you, the patient, being responsible for all costs.

As a courtesy to our patients, we will bill your insurance carrier for any services rendered. However, we do require that any uncovered services, deductibles or co-payments be paid in full at each appointment. Co-payments are estimated based on the information we have obtained from your insurance carrier. We do not guarantee any estimates and should your plan pay or state less than expected, you are fully responsible. We take no responsibility for any denials by dental plans.

In addition, to avoid any confusion or misunderstandings, the following simply states our financial policy regarding payment for professional services.

- Payment is due, in full, as treatment is rendered. Cash, check, Visa, MasterCard, American Express, or Discover card is accepted.
- Payment plans are available through Care Credit. Interest free and extended terms are available. Ask our office staff for more information or an application.
- Balances over 30 days are subject to a 1.5% interest rate (minimum of $5.00) per month.
- Parent/Guardian that brings a minor in for professional services must accept all financial responsibility.
- There is a service charge on all returned checks.
- After 90 days we reserve the right to send a patient balance to collections and additional administrative fees will be applied (35% of the balance).

I have read and fully understand the financial policy outlined above. In addition, I understand that my failure to comply with this policy may result in my account being turned over for collections.

____ ________________________

Signature of Patient, Parent/Guardian Date

Patient Consent to Receive Mail, E-mail, and/or Telephone messages

____

Please Print (Last Name) (First Name) (M.I.) (Date)

I agree that the practice may communicate with me electronically at the following addresses:

_____________________________ ____

Phone Number E-Mail Address *(please print)*

I consent to receive calls and text messages related to my protected healthcare and other services at the phone number(s) above. I understand I may be charged for such calls by my wireless carrier and that such calls may be generated by an automated dialing system.

Do we have your permission to:

Send a recall appointment reminder to your home? Yes____ No____

Leave appointment, billing or dental information on your answering machine/voice mail/e-mail? Yes____ No____

I give permission to share appointment information with the person named below:

__________________________ _____________________ __________________________________

Name **Phone Number** **Email Address**

__________________________ _____________________ __________________________________

Name **Phone Number** **Email Address**

Acknowledgement of Receipt of Notice of Privacy Practices

I, _______________________ have received a copy of this office's Privacy Practices and I understand what I have received.

____

Signature of patient/Parent or Legal Guardian Date

If signed by other than patient, please specify relationship to patient: _______________________________