UPPER EAST SMILES

Child's Information

Last Name: __________________________ First Name: __________________________ Nickname: ___________________
Date of birth: _____/_____/______ Age: _______ Sex: Male / Female Height: _____'______" Weight: _________lbs

Is this your child's first dental visit? YES/ NO Date of last dental visit: ______/______/_______
How was your child's attitude towards previous dental care? ____
How would you expect your child to behave in our office? ____
Describe your child: ☐ Age Appropriate ☐ Anxious ☐ Frightened ☐Outgoing ☐ Shy ☐Stubborn
How may we help make this visit a positive experience for your child? ____
Have we seen other children in your family? YES/ NO Name: ____

How did you hear about our office? ☐ Internet Search ☐ Patient: __________________ ☐ Other: ______________

Medical Information

Physician's Name: ____ Phone #: ____________________________
Date of last medical examination: ______/_______/________
Is your child's general health good? YES/ NO Has there been a change within the last year? YES/ NO
Has your child been hospitalized or had a serious illness? YES/ NO When/ Reason: _____________________________
Is your child taking any medications? YES/ NO What type of medication? ______________________________________

Has your child had a history/ difficulty with any of the following: (**Must check YES or NO**)

YES	NO		YES	NO		YES	NO	
☐	☐	Anemia/ Bleeding problems	☐	☐	Convulsions/ Seizures	☐	☐	Hepatitis
☐	☐	Arthritis/ rheumatism	☐	☐	Developmental	☐	☐	Immune Deficiency
☐	☐	Asthma/ Breathing	☐	☐	Diabetes	☐	☐	Intestinal/ Stomach
☐	☐	Autism	☐	☐	Ears, Eyes, Nose, Throat	☐	☐	Kidney/ Liver
☐	☐	Bones	☐	☐	General Anesthesia/ Surgery	☐	☐	Seasonal Allergies
☐	☐	Cancers/ Tumors	☐	☐	Hearing	☐	☐	Syndromes
☐	☐	Cerebral Palsy	☐	☐	Heart Conditions			
☐	☐	Cleft Lip/ Palate	☐	☐	Others: ______________________________			

Comments/ Details: ____
Allergies to medication or food: ____

Parent/ Legal Guardian 1

Financially Responsible? ☐ YES ☐ NO
Last name: ____________________________________
First name: ____________________________________
Date of birth: ____/_____/______ Sex: Male/ Female
Social Security Number: ________-_______-__________
Are you: ☐ Single ☐ Married ☐ Other
Address: ______________________________________
City: _______________ State: _____ Zip Code: _______
Home # ________________ Cell # __________________
Email address: __________________________________
Employer: ______________________________________
Occupation: ____________________________________

Parent/ Legal Guardian 2

Financially Responsible? ☐ YES ☐ NO
Last name: ____________________________________
First name: ____________________________________
Date of birth: ____/_____/______ Sex: Male/ Female
Social Security Number: ________-_______-__________
Are you: ☐ Single ☐ Married ☐ Other
Address: ______________________________________
City: ________________ State: _____ Zip Code: ______
Home # ________________ Cell # __________________
Email address: __________________________________
Employer: ______________________________________
Occupation: ____________________________________

Dental insurance Information

Insurance Company Name: ___________________________________ Employer: ______________________________
Subscriber's full name: ______________________________________ Date of birth: _____/_____/______
Insurance Identification Number: _________________________ Social Security Number: ______-______-_________
Plan/ Group Number: __________________________________

Financial Policy and Authorization

In my absence, I hereby give authorization for the person(s) listed below to bring my child to Upper East Smiles, P.C and to consent for *diagnostic and preventative* recommended dental services (separate form must be filled out for other services).

Authorized person(s)	Relationship to child	Contact number
___________________________________	_______________________________	(______)________-__________
___________________________________	_______________________________	(______)________-__________
___________________________________	_______________________________	(______)________-__________

I am seeking health care and treatment for _____________________________________ (**child's name**) from Upper East Smiles, PC and voluntarily consent to receive dental services, which may include routine diagnostic and therapeutic dental procedures and routine dental treatment to be provided by duly licensed independent practitioners and other personnel. I acknowledge that no guarantees have been made to me as to the results of treatments or examinations by Upper East Smiles, PC. I understand that this consent is valid and shall remain in effect unless I revoke it. I understand that this general consent applies to any routine procedure or treatment, such as administration of medication, injections, external examination of the body, including the mouth, use of local anesthesia, and other routine procedures.

I consent to the photographing and/or videotaping of the appropriate portions of my/the patient's body, which are pertinent to showing my/the patient's physical condition, for medical, scientific or educational purposes, provided reasonable precautions are taken to conceal my/the patient's identity.

I understand that I may ask questions of my/the patient's licensed independent practitioners and other personnel regarding any aspect of my/the patient's diagnosis or treatments which I do not understand.

I hereby consent to the Practice calling my home, text messaging my cell phone or other designated location and leaving a message on my voicemail or in-person in reference to any items that assist the Practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results and other matters incident to my treatment. I hereby consent to the Practice mailing to my home or other designated location any items that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I hereby consent to the Practice e-mailing/ text messaging me any items or communications that assist the Practice in carrying out TPO, such as appointment reminder cards and patient statements. I understand that I have the right to request that the Practice restrict how it uses or discloses my PHI to carry out TPO. However, the Practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

Your child's estimated share of cost is due and payable on the day the treatment is performed, unless prior approved financial arrangements have been made. Understand that dental insurance may cover only part of your child's dental treatment, based on your specific dental benefit plan. We will do our best to provide you with an estimate based on your plan. Please understand that the contract for dental insurance is between you and your insurance company. Any disputes of coverage need to be handled through the insurance company directly by you.

By signing, I accept as my personal responsibility all charges to my child's account regardless to any insurance coverage.

To avoid missed appointment charges we request that cancellations/ changes are made **24 hours** prior to the appointment. In doing so this appointment may then be made available to another family. A charge of $75.00 will automatically be placed for broken appointments. A broken appointment is considered a "no show" or cancelling an appointment the same day.

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to determine appropriate and healthful dental treatment. If there is any change in my child's medical status, I will inform the dentist.

I authorize the dental insurance company provided to this office, to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize this signature on all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

I authorize Upper East Smiles, PC to access all electronic prescribing medication history databases and to release my prescription medication history contained in and sent to an electronic prescribing medication history database used by Upper East Smiles, PC. I understand that the purpose of this form is for Upper East Smiles, PC to be able to access and exchange medication history information with authorized electronic prescribing services from other providers, pharmacies and/or third-party pharmacy benefit programs/payors.

________________________________	________________________________	__________________
Signature of parent/ guardian	Relationship to patient	Date