smileland
PEDIATRIC DENTISTRY & BRACES

NEW PATIENT FORM

508-986-9722 | www. mysmileland.com

About Your Child

_____
Child's Name

_____
Name Child Prefers To Be Called

_____ _____ _____
Age Gender Date of Birth

_____
Address

_____ _____ _____
City State Zip Code

_____ _____
Home Phone Mobile Phone

_____ _____
Grade Level Hobbies / Pets

_____
Other Children and their ages

_____
Referred to Our Office By (We Wish To Thank Them)

Parent's Marital Status:
☐Married ☐Divorce ☐Separated ☐Widowed ☐Single

Dental History

☐ Yes ☐No Is this your child's first visit to the dentist? If no, when was the last visit and what was done for your child.
_____

☐ Yes ☐No Do you expect your child to be a cooperative patient? If no, please explain.
_____

☐ Yes ☐No Do you have well water at home?
☐ Yes ☐No Does your child take fluoride tablets or vitamins with fluoride?
☐ Yes ☐No Has your child bumped any teeth? If so, when?
_____

☐ Yes ☐No Has your child has a history of headaches, pain, popping or clicking of the jaws?
☐ Yes ☐No Does your child still have a night time bottle?
☐ Yes ☐No Does your child have a toothache?

Does your child have or has he or she had any of the following problems or habits?

☐ Thumb Sucking	How Long?..... Still Active	☐ Yes	☐ No
☐ Finger Habit	How Long?..... Still Active	☐ Yes	☐ No
☐ Pacifier	How Long?..... Still Active	☐ Yes	☐ No

Medical History

Is your child presently under the care of your family physician for any medical reason? ☐ Yes ☐ No If yes, explain
_____
Family Physician's Name:_____
Address: _____
Phone Number: _____

- Is your child in good health? If no, explain ☐ Yes ☐No
_____
- Is your child under the care of a physician other than routine care? If yes, explain ☐ Yes ☐No
_____
- Does your child have any drug allergies? If explain _____ ☐ Yes ☐No
- Is your child taking any medications at this time? If yes, list. ☐ Yes ☐No
_____
- Has your child ever been hospitalized or treated in an emergency room for any particular trauma? When and for what reason? ☐ Yes ☐No
_____
- Does your child have, or has he or she had, any emotional, mental or nervous disorders? If yes, please explain. ☐ Yes ☐No
_____
- Have your child's tonsils and/or adenoids been removed? ☐ Yes ☐No
- Does your child breathe through the mouth? If yes, ☐ Seldom ☐ Often ☐ Yes ☐No

Please indicate if your child has had any of the following:

☐ Allergy to Penicillin	☐ Intellectual disability
☐ Anemia	☐ Latex allergy/sensitivity
☐ Asthma	☐ Liver problems or hepatitis
☐ Autism/Asperger's Syndrome	☐ Malignancies or leukemia
☐ Bleeding disorder	☐ Other drug allergy
☐ Bone disorder	☐ Physical handicap
☐ Cleft palate	☐ Positive for H.I.V.
☐ Diabetes	☐ Radiation treatment
☐ Endocrine disorder	☐ Rheumatic fever
☐ Epilepsy, seizures	☐ Speech problem
☐ Hyperactivity/ADD/ADHD	☐ Tuberculosis
☐ Heart ailment or murmur.	Type, if known_____

Is child under the care of a cardiologist or special physician for the problem? If so, whom _____
Phone _____

Please comment on any problems that were checked in the above areas _____
_____

Do you consider your child to be:

• Advanced in the learning process	☐ Yes	☐ No
• Progressing normally	☐ Yes	☐ No
• A slow learner	☐ Yes	☐ No

Responsible Party

Mothers Full Name

Address

City | State | Zip Code

SS# | Birthdate

Home Phone | Mobile Phone

Business Phone | Employer

Occupation | Email Address

Dental Insurance ☐ Yes ☐ No

Insurance Company | Group or Plan Number

Insurance Company Phone

Father's Full Name

Address

City | State | Zip Code

SS# | Birthdate

Home Phone | Mobile Phone

Business Phone | Employer

Occupation | Email Address

Dental Insurance ☐ Yes ☐ No

Insurance Company | Group or Plan Number

Insurance Comp

Nearest Relative/Friend

Name

Address

City | State | Zip Code

Phone Number | Relationship

In case you are not home, what is your neighbor's

Name | Phone Number

Dental History

How often does your child brush?_____

Is tooth brushing supervised? ☐ Yes ☐ No

By whom?_____

Is dental floss used? ☐ Yes ☐ No

Does your child receive: ☐ Fluoride in vitamins

☐ Fluoride tablets/drops ☐ Bottled water

☐ Fluoridated water ☐ Well water

Financial Information

Methods of Payment:

☐ Check or cash at time of treatment
☐ Visa, MasterCard, American Express or Discover
☐ Insurance form with co-payment at time of treatment
☐ Other: _____

- Payment is expected at time of treatment.
- All emergency patients (being seen for the first time) are required to pay in full at time of treatment.
- Patients with insurance may pay their estimated portion, including deductible, at the time of service. It is the parents responsibility to see that the insurance company makes prompt payment. Any insurance balance over 60 days is due and payable by the parent.

If my account requires servicing by a collection agency or by an attorney, I understand that I will be liable for collection fees, attorney fees, and applicable court costs, in addition to my outstanding balance. I hereby authorize payment directly to Dentistry for Children, the group insurance benefits otherwise payable to me and authorize release of information regarding treatment to the insurance company.

_____

SIGNED (Guarantor)

Acknowledgement of Notice of Privacy

**** YOU MAY REFUSE TO SIGN THIS ACKNOWLEDGEMENT****

I, _____ (print name) have received a copy of this office's privacy practices.

Signature | Date

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not obtained because:

____ Individual refused to sign

____ Communication barrier prohibited signing the acknowledgement

____ An emergency situation prevented from us obtaining acknowledgement

____ Other (please specify)

General Consent

Please read this form carefully. Should you have any questions, our staff will be happy to help you.

1. I hereby authorize and direct the dentist and/or dental auxiliaries to perform dental treatment with the use of any necessary or advisable radiographs (x-rays) and/or any other diagnostic aids in order to complete a thorough diagnosis and treatment plan. _____
Initials

2. I understand x-rays, photographs, models of the mouth, and/or other diagnostic aids used for an accurate diagnosis and treatment planning are the property of the doctors but copies of certain aids are available upon request. _____
Initials

3. In general terms, the dental procedure(s) can include but not limited to:

A. Comprehensive oral examination, radiographs, cleaning of the teeth, and the application of topical fluoride.
B. Application of resin "sealants" to the grooves of the teeth.
C. Treatment of diseased, or injured teeth with dental resto rations (fillings).
D. Treatment of diseased or injured oral tissue secondary to traumatic injuries and/or accidents and/or Infections.

4. I understand that the doctor is not responsible for previous dental treatment performed in other offices. I understand that, in the course of treatment, this previously existing dentistry may need adjustment and/or replacement. I realize that guarantees of results or absolute satisfaction are not always possible in dental health service. _____
Initials

5. I certify that if I, and/or my dependents have insurance coverage I assign directly to the dentist all insurance benefits for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. _____
Initials

6. I have answered all of the questions about me or my dependent's medical history and present health condition fully and truthfully. I have told the dentist or other office personnel about all medical conditions, including allergies. I also understand if my dependent or I ever have any changes in health status or any changes in medication(s), I will inform the doctor at the next appointment. _____
Initials

I hereby acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give this informed consent. I further understand that this consent shall remain in effect until terminated by me.

_____ _____/_____/_____
Patient Name Date of Birth

_____ _____/_____/_____
Parent / Guardia if a minor Relationship to Patient

_____ _____/_____/_____
Signature Date

Written Financial Policy

Thank you for choosing Smileland Pediatric Dentistry & Braces. Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the cost of care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

- **Cash, Check, Visa, Mastercard, American Express or Discover Card**
  - We offer a 10% discounts to patients who pay for their treatment plan in full prior to start of services (cannot be applied to co-pays).
- **Care Credit**
  - Convenient Monthly Payment Plans*1
  - Allow you to pay over time
  - No annual fees or prepayment penalties

Smileland Pediatric Dentistry & Braces requires payment prior to the beginning of your treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care provided and lab fees.

For plans requiring multiple appointments, alternative payment arrangements may be provided. For patients with dental insurance, we are happy to work with your carrier to maximize your benefit and directly bill them for reimbursement for your treatment.

Smileland Pediatric Dentistry & Braces charges $35 for returned checks and $15 for accounts sent to collections.

You grant permission to us or our assignee, to telephone you to discuss this statement or your treatment. I understand that any fee estimate for this dental care can only be extended for a period of three months from the date of patient examination.

All emergency dental services, or any dental services performed without previous financial arrangements must be paid for at the time services are performed unless other arrangements are made.

I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if suit be instituted hereunder. If you have any questions, please do not hesitate to ask.

_____
Patient, Parent or Guardian Signature

____/____/_____
Date

_____
Patient Name (Please Print)

Subject to credit approval
However, if we do not receive payment from your insurance carrier within 60 days or after we make 3 attempts, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier. If your account balance is not settled at the time of appointment, our office will invoice you for the balance on a monthly basis for up to 3 invoices. Any account that is over 90 days past due will be assigned to a collection agency for further billing.