



Smiles4Kids

DENTISTRY FOR CHILDREN

Welcome!

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

PATIENT INFORMATION

Date _____ Birthdate _____

Name of Minor/Child _____ Sex M F Age _____
Last Name First Name Middle Initial

Nickname _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Person financially responsible _____

How did you hear about our office? _____

PARENT/GUARDIAN INFORMATION

Father's/Guardian's Name _____	Mother's/Guardian Name _____
Address (if different from patient's) _____	Address (if different from patient's) _____
Home Phone () _____ Work Phone () _____	Home Phone () _____ Work Phone () _____
E-mail _____ Cell Phone () _____	E-mail _____ Cell Phone () _____
Employer _____	Employer _____
Soc. Sec. # _____ Birthdate _____	Soc. Sec. # _____ Birthdate _____
Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No	Do you have dental insurance coverage for minor/child? <input type="checkbox"/> Yes <input type="checkbox"/> No
Carrier: _____ Phone () _____	Carrier: _____ Phone () _____
Address _____	Address _____
Group # _____ Subscriber ID: _____	Group # _____ Subscriber ID: _____

Is your child eligible under the Idaho Smiles Program? Yes No Idaho Smiles # _____

DENTAL HISTORY

Date of last visit to a dentist _____ For what service? _____

	YES	NO		YES	NO
Has child complained about dental problems?.....	<input type="checkbox"/>	<input type="checkbox"/>	Is flouride taken in any form?.....	<input type="checkbox"/>	<input type="checkbox"/>
Does child brush teeth daily?.....	<input type="checkbox"/>	<input type="checkbox"/>	Any injuries to mouth, teeth, head?.....	<input type="checkbox"/>	<input type="checkbox"/>
Does child use floss every day?.....	<input type="checkbox"/>	<input type="checkbox"/>	Any unhappy dental experiences?.....	<input type="checkbox"/>	<input type="checkbox"/>
Any mouth habits - thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc. ?.....				<input type="checkbox"/>	<input type="checkbox"/>

See Back Please ➡

MEDICAL HISTORY

Minor/Child's Physician _____ City/State _____ Phone (____) _____

Date of last physical examination _____

	YES	NO	Medications _____
Receiving any medication or drugs?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever been hospitalized?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ever had surgery?.....	<input type="checkbox"/>	<input type="checkbox"/>	Allergies _____
Is there excessive bleeding when cut?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____

Has minor/child had any history of or difficulty with any of the following? If yes, please check (✓)

<input type="checkbox"/> ADHD	<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> A.I.D.S./H.I.V.	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Fainting	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Sinus Problems
<input type="checkbox"/> Anemia	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Hearing Problems	<input type="checkbox"/> Measles	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Asthma/Lung Problems	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Heart Problems/Murmur	<input type="checkbox"/> Mononucleosis	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bladder Problems	<input type="checkbox"/> Drug/Alcohol Abuse	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Mumps	<input type="checkbox"/> Other
<input type="checkbox"/> Cancer				

Is there any disease, condition or problem that is not listed above?
Please describe _____

EMERGENCY CONTACT

Name of nearest friend or relative, in case of emergency. (Person Not Living With You)

Name _____ Relationship _____ Phone (____) _____

Name _____ Relationship _____ Phone (____) _____

AUTHORIZATIONS

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health. Int. _____

Minor/Child Consent
I am the parent, guardian, or personal representative of _____
Please Print Name of Minor/Child _____

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor. I understand I must be present when the treatment is rendered unless prior written consent is given. _____
Signature of Parent/Guardian

Insurance Assignment and Release
As a courtesy to you, we will process your insurance forms and claims. **However, your insurance policy is an agreement you have with your insurance carrier. If you have questions regarding payments from your insurance company, we recommend that you call your insurance provider directly for the most accurate and speedy answer.** It is the parent's/guardian's responsibility to pay for any deductible or other balance not covered by the insurance. Regardless of insurance, I agree the balance will be paid in full within 60 days of treatment, unless previous arrangements have been made. Should my account exceed ninety days, one percent (1%) interest per month, twelve percent (12%) per year will be charged. I certify that my dependent is covered by insurance with _____ and assign all insurance benefits directly to Smiles 4 Kids. I authorize the use of my signature on all _____
Name of Insurance Carrier

insurance submissions. I give permission for Smiles 4 Kids to use health care information and may disclose such information for the purpose of obtaining payment for service and determining insurance benefits.

Signature of Parent/Guardian

Print name of Parent/Guardian

Relationship to Patient

Date