NATURAL SMILES
PEDIATRIC DENTISTRY

Patient Information

Today's Date: / /

Patient: LAST FIRST INITIAL	Nickname	Date of Birth / /
Address STREET CITY STATE ZIP CODE		
Phone HOME	CHILD'S SOC SEC#	Sex: M F
SCHOOL	GRADE	HOBBIES
Child primarily lives with	Person financially responsible	
How did you hear about our practice?		
Father: ☐ Stepfather ☐ Guardian Marital Status: ☐M☐S☐D☐W☐ LAST FIRST INITIAL	E-Mail	
Address (If Different from Above) STREET CITY STATE ZIP CODE		
Phone HOME CELL WORK EXT		
Employer	Date of Birth / /	Driver's License #
Mother: ☐ Stepmother ☐ Guardian Marital Status: ☐M ☐S ☐D ☐W LAST FIRST INITIAL	E-Mail	
Address (If Different from Above) STREET CITY STATE ZIP CODE		
Phone HOME CELL WORK EXT		
Employer	Date of Birth / /	Driver's License #
Who should we contact regarding your child's appointment?		
How would you prefer to be contacted?		
Insurance Information: Policy Holder	SS#	Date of Birth / /
Employer	Relationship to Patient	
Insurance Company	Group Number	Policy Number
Mailing Address	Phone Number	
Emergency Contact: LAST FIRST	Relationship to Patient	
Address STREET CITY STATE ZIP CODE		
Phone HOME CELL WORK EXT		

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Medical History

Patient:
LAST FIRST MIDDLE INITIAL

Medical Information
Child's Pediatrician: Phone Number:

Date of Last Physical: / /

Are your child's immunizations up to date? ☐ YES ☐ NO

Current Physical Health: ☐ Excellent ☐Fair ☐ Poor

Is your child currently under the care of a physician? ☐ YES ☐ NO
If yes, explain:

Has your child ever been hospitalized, sedated or had surgery? ☐ YES ☐ NO
If yes, explain:

Has your child ever had a serious head or neck injury? ☐ YES ☐ NO
If yes, explain:

Is your child taking any medications? ☐ YES ☐ NO
List:

Is your child on a special diet? ☐ YES ☐ NO
List:

Does your child have any allergies to medicines, latex, food or metals? ☐ YES ☐ NO
List:

Is your child allergic to Penicillin? ☐ YES ☐ NO
Any other drug allergies? Please list below.

Are antibiotics necessary for dental work due to a heart murmur, heart defect, prosthesis, shunt or any other reason? ☐ YES ☐ NO
If yes, explain:

Has any member of the family, including your child, had a problem with sedation or general anesthesia? ☐ YES ☐ NO
If yes, explain:

Does your child have any handicaps or disabilities? ☐ YES ☐ NO
If yes, explain:

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Medical History

Please check if your child has had any history of, or conditions relating to, any of the following:

☐ Abnormal Bleeding	☐ Cleft Palate/Lip	☐ Growth Problems/Delays	☐ Mononucleosis
☐ ADD/ADHD	☐ Cold Sores/Fever Blisters	☐ Hayfever/Allergies	☐ Mumps
☐ AIDS/HIV+	☐ Congenital Heart Defect	☐ Hearing Impairment	☐ Pain in Jaw Joints
☐ Anaphylaxis	☐ Convulsions	☐ Heart Murmur	☐ Vision Impaired
☐ Anemia	☐ Cortisone (Steroid) Medicine	☐ Heart Trouble/Disease	☐ Premature Birth
☐ Asthma	☐ Diabetes	☐ Hemophilia	☐ Psychiatric Care
☐ Autism	☐ Down Syndrome	☐ Hepatitis	☐ Recent Weight Loss
☐ Behavioral Problems	☐ Drug/Alcohol Abuse	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Birth Defects	☐ Earaches/Ear Infections	☐ Hives/Rash	☐ Scarlet Fever
☐ Bladder Problems	☐ Easily Winded	☐ Hypoglycemia	☐ Sickle Cell Disease
☐ Blood Disease	☐ Eating Disorder	☐ Irregular Heart Beat	☐ Sinus Problems
☐ Blood Transfusions	☐ Epilepsy/Seizures	☐ Kidney Problems	☐ Speech Impairment
☐ Brain Injury	☐ Excessive Bleeding	☐ Learning Disabilities	☐ Spina Bifida
☐ Breathing Problem	☐ Excessive Thirst	☐ Leukemia	☐ Stomach/Intestinal Problems
☐ Bruise Easily	☐ Fainting/Dizziness	☐ Liver Disease	☐ Thyroid Disease
☐ Cancer/Tumor	☐ Frequent Cough	☐ Low Blood Pressure	☐ Tonsillitis
☐ Cerebral Palsy	☐ Frequent Diarrhea	☐ Lung Disease	☐ Tuberculosis
☐ Chicken Pox	☐ Frequent Headaches	☐ Measles	☐ Yellow Jaundice

Is there any other health information that should be known? ☐ YES ☐ NO

If yes, explain:

To the best of my knowledge, the questions on this Medical History Form have been accurately answered. I understand that providing incorrect information is dangerous to my child's health. It is my responsibility to inform Natural Smiles Pediatric Dentistry of any changes to my child's medical status.

Signature of Parent/Guardian _____ Date _____

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Dental History

Patient:

Last: First: Middle Initial: Nickname: Age:

Previous Dentist Name: **Phone Number:**

Date of Last Dental Visit: / / Date of Last Cleaning: / Date of Last X-Rays: /

Do you have a copy of your child's previous x-rays? ☐ YES ☐ NO

Has your child been to an orthodontist for an evaluation? ☐ YES ☐ NO

Is your child currently seeing an orthodontist? ☐ YES ☐ NO

Orthodontist Name: **Phone Number**

Does your child have a history of unfavorable reactions to the dentist? ☐ YES ☐ NO
If yes, explain:

My child brushes _____times per day.

My child flosses every day: ☐ YES ☐ NO

Is tooth brushing supervised? ☐ YES ☐ NO

Is fluoride taken in any form? ☐ YES ☐ NO

Has there been any previous injuries to your child's mouth, teeth or jaw? ☐ YES ☐ NO
If yes, explain:

Does your child:

☐ Use a Pacifier	☐ Chew/Bite Nails	☐ Clench their Jaw
☐ Suck Thumb/Fingers	☐ Chew Hard Objects	☐ Breathe through Mouth
☐ Sleep with a Bottle/Sippy Cup	☐ Grind Teeth	☐ Snore

For children under 5, was/is your child being: ☐ Breast-Fed ☐ Bottle-Fed

Reason for today's visit:

Is your child experiencing any dental pain? ☐ YES ☐ NO
If yes, explain:

Does your child have a specific dental problem that needs attention? ☐ YES ☐ NO
If yes, explain:

Pharmacy Name: Location: **Phone Number**

Consent for Treatment

To the best of my knowledge, the information given herein is accurate and complete. It is my responsibility to inform Natural Smiles Pediatric Dentistry of any changes in my child's dental or medical status.

I am the parent or legal guardian of _____ and there are no court orders in
Please Print Name of Minor/Child
effect that prohibits me from signing this consent. I do hereby request and authorize Dr. Rankin and/or her staff to perform necessary dental procedures for the child named above, including but not limited to, x-rays, the administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

All procedures will be discussed with you prior to any dental treatment.

Signature of Parent or Legal Guardian

_____ _____
Please Print Name of Parent or Legal Guardian Relationship to Patient

Date:

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Policy Agreements

Financial Policy Agreement

Payment in full is expected at each appointment. If requested before treatment, we will provide an estimate of charges to be completed.

Patients with insurance:
Our office will file with your insurance company as a courtesy. Keep in mind we can only estimate what your portion will be, which is due the day of treatment. You will be billed the difference if the insurance company pays less than the actual bill for service. Regardless of your insurance benefits, you are responsible for charges incurred and remaining balances. It may take up to four weeks for our office to receive insurance payments. If insurance payment is not received in 45 days , we ask that you contact your insurance company.

Sedation Appointments:
There is a $175 fee for a sedation appointment. This fee may not be covered by insurance. Since we reserve a chair for our patient for the entire morning, the $175 fee is non-refundable without a 48-hour notice of cancellation. This fee is due at the time you schedule your sedation appointment.

Broken Appointments:
We reserve the right to charge for any broken appointments. Charges for broken appointments with the dentist may be up to $40 if less than one hour. Appointments over an hour can be $60. Broken hygiene appointments will be at a rate of $30. We ask that a 24 hour notice be given for any cancellations. If less that a 24 hour notice is given, it is considered a broken appointment with the exception of an emergency. We also reserve the right to dismiss a patient due to broken appointments.

Confirming Appointments:
We will attempt to confirm appointments a week prior and again two days before. We reserve the right to cancel appointments if they are not confirmed 24 hours before their scheduled time.

After Hours Policy
Narcotics will not be called in after hours or on weekends nor will narcotics be given when treatment is not rendered.

Authorization and Release

I authorize Natural Smiles Pediatric Dentistry to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or health practitioners.

I authorize and request my insurance company to pay directly to Natural Smiles Pediatric Dentistry insurance benefits otherwise payable to me.

My signature acknowledges that I have read and understand the policies as stated above and agree to be responsible for payment of all services rendered on my behalf or my dependent's behalf.

Patient's First Name: _____ Patient's Last Name:_____ DOB: / /

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HIPAA AND NOTICE OF PRIVACY PRACTICES

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your child's protected health information, and of other important matters about your child's protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat your child or to continue treating your child if you revoke this Consent.

I have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my child's protected health information to carry out treatment, payment activities and healthcare operations.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your child's protected health information to carry out treatment, payment activities, and healthcare operations.

Abuse or Neglect: We are required by law to report any abuse or neglect to the proper official. We may disclose your child's health information to appropriate authorities if we reasonably believe that your child is a possible victim of abuse, neglect or domestic violence, or possible victim of other crimes. We may disclose your child's health information to the extent necessary to avert a serious threat to your child's health or safety, or the health or safety of others.

Marketing Health - Related Services: We will not use your child's health information for marketing communications without your written authorization. Required by Law: We may use or disclose your health information when we are required to do so by law.

I have received the Natural Smiles Pediatric Dentistry Hipaa and Notice of Privacy Practices handout provided to me at registration.

Patient's First Name: _____ Patient's Last Name:_____ DOB: / /

SIGNATURE OF PARENT/GUARDIAN: _____ **DATE:**_____

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RECORDS RELEASE FORM

Natural Smiles Pediatric Dentistry
2338 Hwy 62 W
Mountain Home, AR 72653
Phone 870-424-4670
Fax 870-232-5269

Please email x-rays to naturalsmilespd@gmail.com

My permission is granted to disclose complete information concerning the medical and dental findings and treatment to Natural Smiles Pediatric Dentistry from all dates.

I release (name of dental office) : _____

from any laws related to disclosure of confidential or privileged information.

Patient(s) name and date of birth : _____

Parent/Guardian name and phone number : _____

Address : _____

Parent/Guardian Signature: _____

Witness : _____

Date : _____

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