PediatricSmiles
Dentistry for Infants, Children & Teens
ANITA MURRAY-CLARY, DDS

Patient's Name ______________________________________Preferred Name ________________________ Sex __________

Date of Birth _____________ Age________ Weight __________ School ____

Child lives with: Both parents _____ Mother _____ Father _____ Other ____

Names and ages of brothers and sisters ____

Child's physician _____________________________________ Previous dentist ___________________________________

Whom may we thank for referring you? ____

If you are being referred by another dentist, what is the reason for referral?____

PARENT/GUARDIAN INFORMATION

Mother's/Guardian's Name ___________________________________Email address __________________________________

Mailing address ____
Street City State Zip

Home Phone ________________________ Work Phone ________________________ Cell Phone ______________________

Birthdate _________ Age _____ Social Security # ________________________

Employer __________________________________Occupation ___________________________ Years Employed_________

Father's/Other Parent's Name _________________________________Email address ________________________________

Mailing address ____
Street City State Zip

Home Phone ________________________ Work Phone ________________________ Cell Phone ______________________

Birthdate _________ Age _____ Social Security # ________________________

Employer __________________________________Occupation ___________________________ Years Employed_________

Marital Status of Parents: Married _______ Divorced ______ Separated ______ Single ______

DENTAL INSURANCE INFORMATION

Primary Dental Insurance Co __________________________________ Group#___________________________________
Insured's Name__________________________________DOB________ Insured ID#/Healthwave ID#___________________
Insured's Employer ____ Phone____________________________________
Secondary Dental Insurance Co_________________________________ Group # __________________________________
Insured's Name _________________________________ DOB________ Insured ID#/Healthwave ID#__________________
Insured's Employer ____ Phone____________________________________

EMERGENCY INFORMATION

Name of nearest relative or friend not living with you _______________________ Relationship to patient _______________
Address ____ Phone _________________________
Street City State Zip

PATIENT HEALTH/MEDICAL HISTORY

It is important that we are aware of your child's health history. Please complete this section thoroughly. Please check yes or no, circle and explain where appropriate. Has your child had a history or difficulty with any of the following:

(Y) (N)		(Y) (N)		(Y) (N)	
( )( )	AIDS or HIV infection	( )( )	Hepatitis or Jaundice	( )( )	Heart Disorder or Murmur
( )( )	Seasonal Allergies	( )( )	Kidney or Liver Disease	( )( )	Lung Problems or Chronic Obstructive Pulmonary Disease
( )( )	Asthma	( )( )	Arthritis or Rheumatism		
( )( )	Hay Fever	( )( )	Hearing Disorder	( )( )	Surgery
( )( )	Frequent Headaches	( )( )	Speech Disorder	( )( )	Ulcers
( )( )	Cerebral Palsy	( )( )	Nervous System Disorder	( )( )	Other
( )( )	Autism	( )( )	Sexually Transmitted Disease		______________________________
( )( )	ADD/ADHD/OCD (circle)	( )( )	Tuberculosis		
( )( )	Emotional Disturbance	( )( )	Anemia or Bleeding Disorder		______________________________
( )( )	Psychiatric Treatment	( )( )	Diabetes		
( )( )	Mental Retardation	( )( )	Brain Injury		______________________________
( )( )	Developmental Disability	( )( )	Fainting/Seizures/Epilepsy		
( )( )	Age/level of function (in years) ___________		____________________________________ Please explain		

List any drugs or medications presently taking (dosage/times per day)______________________________

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List any <u>allergies to drugs</u> or <u>medication</u> ____

	(Y) (N)
Has your child been diagnosed as having any disorder, disease or syndrome not listed above?	( )( )
If yes, explain ____	
Has your child had abnormal bleeding associated with previous surgery, extractions or accidents?....................	( )( )
Has your child ever required a blood transfusion?	( )( )
Does he/she bruise easily?	( )( )
Has your child ever had surgery, x-ray or chemotherapy for a tumor, growth or other condition?	( )( )
Please explain ____	
Is your child currently pregnant or may be?	( )( )
Is your child currently taking birth control pills?	( )( )
Is your child under medical care?	( )( )
Is this your child's first visit to the dentist?	( )( )
Do you/your child feel nervous or concerned about dental treatment?	( )( )
Please explain ____	
Has your child had any unfavorable experiences in a dental/medical environment?	( )( )
Please explain ____	
Have you been satisfied with your child's previous dental care?	( )( )
What is your main concern about your child's dental health? ______________________________	
Has your child ever complained about pain or is there pain or discomfort presently?	( )( )
Is your child currently taking fluoride in any form? If yes, please explain ______________________________	( )( )
Is your water non-fluoridated/do you drink bottled or filtered water?	( )( )

PATIENT HEALTH/MEDICAL HISTORY (CONT'D)

Is there any history of nail biting, thumb or finger sucking, mouth breathing, pacifier use? (Please circle) Past/Current ….….…. ( )( )

Does he/she grind or clench teeth? ……………………………………………………………………………………….… ( )( )

Have orthodontic appliances been worn now or ever? …………………………………………………………………….. ( )( )

Is there a history of trauma or injury to the teeth, jaws or head? ………………………………………………………… ( )( )

Please explain ____

Does your child brush his/her teeth daily? …………………………………………………………………………………. ( )( )

Does an adult assist child with brushing? ………………………………………………………………………………….. ( )( )

Is your child currently breast or bottlefeeding? ……………………………………………………………………………… ( )( )

At what age did he/she stop? ____________

Would you describe your child to be ( ) Nervous ( ) Highstrung ( ) Hyperactive ( ) Shy ( ) Frightened ( ) Uncooperative ( ) Negative ( ) Other ____

Intellectual Development: ( ) Advanced ( ) Normal Rate ( ) Delayed If your child is in a special educational program or structure, please explain.____

***Thank you* for carefully answering the questions on this form. If there is any information you feel would assist us in the treatment of your child or make his dental experience more comfortable, please add here.**

____

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CONSENT

The signature of the parent or guardian below authorizes completion of all agreed upon dental treatment and the use of proper and acceptable methods to perform the same. Please be aware that the parent bringing the child for dental care must be legally responsible for payment of all fees.

I hereby grant permission to the staff of this office for the performance of such diagnostic and therapeutic procedures as may be necessary for proper dental care. I also grant permission to share information about my child to my referring dentist, other involved parties and my insurance company. To the best of my knowledge, all information as answered on this form is correct. I will inform the office of Pediatric Smiles of any changes in health status and/or use of medications and any applicable insurance information. I hereby authorize payment of all insurance reimbursement directly to Pediatric Smiles, Anita Murray-Clary, DDS. I fully understand this consent and have no further questions. I understand I will be asked periodically to complete a new form, or at the discretion of Pediatric Smiles. Finally, I accept responsibility for payment of services rendered, regardless of insurance coverage.

Date _______________ Signature of Parent or Legal Guardian ____

Periodic Review of Patient Information (To be reviewed/signed after initial visit)

I have made changes to the original patient information form. To the best of my knowledge, the information contained on this form is correct as of the date of my signature.

Date	Signature of Parent or Legal Guardian
____________________	____
____________________	____

Written Financial Policy

At Pediatric Smiles we believe that your child deserves the best care. That's why we always present you with the best dental solution possible to treat your child's personal situation. Our primary mission is to deliver the finest and most comprehensive dental care available. An important part of the mission is making the cost of optimal care as easy and manageable for our patients as possible by offering several payment options.

Payment Options:

You can choose from:

- Cash, Check, Electronic Funds Transfer, Visa, Mastercard or Discover Card
- We offer a 5% courtesy accounting adjustment to patients who pay their full estimated patient portion (minimum $300) with cash or check two weeks prior to treatment.
- Convenient Monthly Payment Plans[1] from CareCredit
    - Minimum purchase of $300
    - Payment plan over 6 or 12 months with no interest
    - No annual fees or pre-payment penalties

Please note:

Pediatric Smiles requires payment of 50% of your estimated patient portion prior to the onset of treatment. If you choose to discontinue care before treatment is complete, you will receive a refund less the cost of care received. For plans requiring multiple appointments, alternative payment arrangements may be provided. We charge 10% interest on all accounts over 60 days old from the date of service. Delinquent accounts will be turned over to a collection attorney and you promise to pay all costs of collection including but not limited to court costs and reasonable attorney fees.

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.[2]

Pediatric Smiles charges $25 for returned checks.

Thank you for choosing Pediatric Smiles. If you have any questions, please do not hesitate to ask.

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Patient, Parent or Guardian Signature   Date

____

Patient Name (Please Print)

[1] Subject to credit approval

[2] However, if we do not receive payment from your insurance carrier within 60 days, you will be responsible for payment of your treatment fees and collection of your benefits directly from your insurance carrier.

6231 SW 29th SREET, Ste 100 ◆ TOPEKA, KS 66614 ◆ 785-272-6060
asmileisforever.com

PediatricSmiles

ANITA MURRAY-CLARY, DDS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of or had the opportunity to review the currently effective Notice of Privacy Practices for Anita C. Murray-Clary, DDS.

Patient Name ____
LAST FIRST MI

Please Print Your Name ____
LAST FIRST MI

Your Signature____

Today's Date ____

Do Not Write Below -- For Office Use Only

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

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (Please Specify)

____

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Received by ________________________________ Date __________

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