

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)
<input type="checkbox"/> <input type="checkbox"/> AIDS or HIV infection
<input type="checkbox"/> <input type="checkbox"/> Seasonal Allergies
<input type="checkbox"/> <input type="checkbox"/> Asthma
<input type="checkbox"/> <input type="checkbox"/> Hay Fever
<input type="checkbox"/> <input type="checkbox"/> Frequent Headaches
<input type="checkbox"/> <input type="checkbox"/> Cerebral Palsy
<input type="checkbox"/> <input type="checkbox"/> Autism
<input type="checkbox"/> <input type="checkbox"/> ADD/ADHD/OCD (circle)
<input type="checkbox"/> <input type="checkbox"/> Emotional Disturbance
<input type="checkbox"/> <input type="checkbox"/> Psychiatric Treatment
<input type="checkbox"/> <input type="checkbox"/> Mental Retardation
<input type="checkbox"/> <input type="checkbox"/> Developmental Disability
<input type="checkbox"/> <input type="checkbox"/> Age/level of function
(in years) _____ | (Y) (N)
<input type="checkbox"/> <input type="checkbox"/> Hepatitis or Jaundice
<input type="checkbox"/> <input type="checkbox"/> Kidney or Liver Disease
<input type="checkbox"/> <input type="checkbox"/> Arthritis or Rheumatism
<input type="checkbox"/> <input type="checkbox"/> Hearing Disorder
<input type="checkbox"/> <input type="checkbox"/> Speech Disorder
<input type="checkbox"/> <input type="checkbox"/> Nervous System Disorder
<input type="checkbox"/> <input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> <input type="checkbox"/> Tuberculosis
<input type="checkbox"/> <input type="checkbox"/> Anemia or Bleeding Disorder
<input type="checkbox"/> <input type="checkbox"/> Diabetes
<input type="checkbox"/> <input type="checkbox"/> Brain Injury
<input type="checkbox"/> <input type="checkbox"/> Fainting/Seizures/Epilepsy

Please explain | (Y) (N)
<input type="checkbox"/> <input type="checkbox"/> Heart Disorder or Murmur
<input type="checkbox"/> <input type="checkbox"/> Lung Problems or Chronic
Obstructive Pulmonary Disease
<input type="checkbox"/> <input type="checkbox"/> Surgery
<input type="checkbox"/> <input type="checkbox"/> Ulcers
<input type="checkbox"/> <input type="checkbox"/> Other

_____ |
|---|--|---|

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

List any allergies to drugs or medication _____

Has your child been diagnosed as having any disorder, disease or syndrome not listed above? (Y) (N)

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.

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 Plans¹ from CareCredit
 - o Minimum purchase of \$300
 - o Payment plan over 6 or 12 months with no interest
 - o 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.

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.

