Sunny Smiles Pediatric Dentistry

PATIENT INFORMATION

Patient: _____

Today's Date: _____

Nickname/Preferred Name: _____ Date of Birth: _____ Age: _____ Sex: M F

School: _____

Grade: _____

Home Address: _____ City: _____ Zip: _____

Phone Number: _____

Social Security Number: _____

Who has legal custody of this patient? _____

How did you hear about our office?

☐ **Online/Google** ☐ **Referral from Dr._____** ☐ **Drive By**

☐ **Facebook** ☐ **Referral from a current patient: _____** ☐ **Other: _____**

Reason for today's visit: _____

MOTHER'S INFORMATION:

Name: _____

Date of Birth: _____

Employer: _____

Social Security Number: _____

Work Phone #: _____ Home Phone #: _____

Cell Phone #: _____ **Appointment reminders via text: ☐ Yes ☐ No**

FATHER'S INFORMATION:

Name: _____

Date of Birth: _____

Employer: _____

Social Security Number: _____

Work Phone #: _____ Home Phone #: _____

Cell Phone #: _____ **Appointment reminders via text: ☐ Yes ☐ No**

PERSON FINANCIALLY RESPONSIBLE FOR ACCOUNT:

Name: _____

Relationship to Patient: _____

Billing Address: _____City: _____ Zip: _____

Work Phone #: _____ Home Phone #: _____

Cell Phone #: _____

E-mail address: _____

INSURANCE INFORMATION

Dental Insurance Company: _____

Group #: _____

Phone #: _____

Name of Insured: _____

HEALTH INFORMATION

Physician's Name: _____

Phone #: _____

Date of last physical: _____

Please list any known allergies: _____

Please list all current medications this patient is taking, including the reason for taking the medication:

_____

_____

Y N Does your child need pre-medication with antibiotics before dental appointments?

Y N Has your child ever been hospitalized?
If yes, please describe when and why: _____

Y N Has your child ever been treated in the emergency room?
If yes, please describe when and why: _____

Y N Has your child ever had surgery?
If yes, please describe when and why: _____

Has your child ever been diagnosed with or treated for the following?

Y N ADHD/Hyperactivity	Y N Breathing Problems	Y N Heart Murmur	Y N Premature Birth
Y N Allergies	Y N Cancer/Tumor	Y N Hepatitis	Y N Rheumatic Fever
Y N Anaphylactic Shock	Y N Cerebral Palsy	Y N High Blood Pressure	Y N Seizures/Epilepsy
Y N Anemia	Y N Cleft Lip/Palate	Y N HIV/AIDS	Y N Sleep Apnea
Y N Arthritis	Y N Delayed Speech	Y N Kidney Disease	Y N Sickle Cell Disease
Y N Artificial Joints	Y N Developmental Delay	Y N Latex Sensitivity	Y N Sinus Problems
Y N Asthma	Y N Diabetes	Y N Liver Disease	Y N STD
Y N Birth Defects	Y N Fainting Spells	Y N Low Birth Weight	Y N Tonsillectomy
Y N Bladder Disease	Y N Head/Neck Injury	Y N Mental/Nervous Disorder	Y N Tuberculosis
Y N Bleeding Problems	Y N Hearing Impairment	Y N Pacemaker	Y N Vision Problems
Y N Blood Disorder	Y N Heart Condition	Y N Pregnancy	Y N Other

If other, please specify: _____

Please elaborate on any of the above marked yes: _____

_____

DENTAL INFORMATION

When was your child's last dental visit? _____

Previous dentist's name and address: _____

Why did your child leave his/her previous dentist? _____

When were X-rays last taken of your child's teeth? _____

Y N Do you have any concerns regarding his/her teeth?

Y N Does your child clench or grind his/her teeth?

Y N Does your child have any tooth, jaw, or muscle discomfort?

Y N Does your child have frequent headaches?

Y N Does your child have a click, pop, or other noise in the jaw joint?

Y N Are your child's teeth sensitive to hot or cold?

Y N Are any of your child's teeth uncomfortable for him/her when he/she bites?

Y N Do your child's gums bleed when brushing or flossing?

Y N Does your child have any concerns about the appearance of his/her teeth?
Y N Does your child have a history of an accident or injury involving the teeth/jaws?
Y N Does your child get cold sores or canker sores?
Y N Does your child have a habit of snoring or mouth breathing?
Y N Does your child have a current or previous habit involving a pacifier or thumb/finger sucking?
Y N Does your child have a history of going to sleep with a baby bottle or on demand breast feeding?
Y N Does your child frequently eat sweets and/or drink juices or sodas?
Y N Does your child only drink bottled, highly-filtered, or well water?
Y N Do you supervise or assist your child in brushing his/her teeth?
Y N Does your child use toothpaste with fluoride?
Y N Does your child use fluoride tablets or rinses?
Y N Does your child use dental floss?

How has your child reacted to previous medical or dental procedures? _____
How do you expect your child to react in the dental chair? _____
What are your child's interests and hobbies? _____
Please list any conditions or concerns regarding your child's health that have not been covered in this questionnaire: _____

I, the undersigned parent/legal guardian of this child, certify that the above is accurate and complete to the best of my knowledge. I will notify the dentist and/or the staff of any change in the above prior to any appointment.

Signature: _____ Name: _____
Date: _____ Relationship to Patient: _____

CONSENT FOR DENTAL TREATMENT

I, the undersigned parent/legal guardian, hereby give consent for the dentist and/or clinical staff to examine this child, clean his/her teeth, perform all necessary dental treatment, administer local anesthetics, administer medications, apply topical fluoride, take diagnostic radiographs (X-rays), take clinical photographs, obtain study models and other records necessary for an accurate diagnosis for my child. I understand that dental treatment for children involves behavior guidance, which may include the use of praise, explanation and demonstration of procedures and instruments, variable voice tone, mouth props, nitrous oxide (laughing gas), or protective stabilization when necessary to promote cooperative behavior and a positive experience and to protect my child from potential injury.

Signature: _____ Name: _____
Date: _____ Relationship to Patient: _____

Feedback Consent

Sunny Smiles Pediatric Dentistry reserves the right to send text communications regarding practice updates, marketing promotions and feedback requests. I understand that by providing a cell phone number, I agree to receive texts from Sunny Smiles Pediatric Dentistry. At any point, you can opt-out. Message and data rates may apply. Thank you for being a valued patient of Sunny Smiles Pediatric Dentistry."

(Initial Here) _____

Sunny Smiles Pediatric Dentistry
8525 Dr. MLK Jr. St. North
St. Petersburg, FL 33702
(727) 914-6611

APPOINTMENT POLICY

Our office strives to provide optimum treatment and convenience for our patients by offering accommodating and flexible scheduling.

Therefore, we ask that you help us by keeping your scheduled appointments, and by notifying our office in advance if you are unable to do so.

We have a waiting list for appointments and when given advance notice we are often able to accommodate other patients.

ALL PATIENTS WHO FAIL TO ARRIVE FOR THEIR SCHEDULED APPOINTMENTS OR WHO MAKE CHANGES WITH LESS THAN 48 BUSINESS HOURS ADVANCE NOTICE WILL BE SUBJECT TO A MISSED APPOINTMENT FEE

- Missed appointment fees are **NOT** covered by insurance plans and are your responsibility to pay
- If you need to change an appointment, please give us at least **48 business hours'** notice
- If you fail to show for your appointment and have not notified our office in advance, a missed appointment fee will be imposed.
- If you miss two consecutive appointments, any future appointments scheduled with us will be removed from our calendar and referring dentist will be notified.

Thank you for your cooperation.

Patient Name (please print): _____

Signature below indicates I have read and understand this policy.

Patient (18 or older) or Legal Guardian Signature: _____

Sunny Smiles Pediatric Dental Office
8525 Dr. MLK Jr. St. North
St. Petersburg, FL 33702
(727) 914-6611

INSURANCE BENEFIT ACKNOWLEDGEMENT

Having dental coverage is not a substitute for payment. Dental insurance is a contract between you and your insurance company. Many companies have fixed allowances or percentages based on the contract you have with them, not with our office, however we are dedicated to assisting you with this process. It is your responsibility to pay your deductible, coinsurance, and any other balances not paid by your insurance company.

In determining the amount of benefits payable, your insurance company may give consideration to an alternate procedure that may accomplish a professional satisfactory result or be accepted as the basic standard of care. As we strive to provide the highest standard of care, what your insurance company is willing to pay for and the services we provide may differ. If an alternate benefit provision is applied to a procedure performed by your dentist and submitted to your insurance company as a claim, the amount of money you owe your dentist may be more than the amount specified on the Explanation of Benefits (EOB).

Estimates of coverage are not a guarantee of payment as eligibility, policy provisions and possible charges from other offices affect the final payment received. YOU ARE RESPONSIBLE FOR ALL TREATMENT CHARGES NOT PAID BY YOUR INSURANCE COMPANY.

I agree to pay the fees, including any deductible, co-insurance, and any other balances not paid by my insurance company, to Sunny Smiles Pediatric Dentistry.

_____ _____
Signature of Patient/ Legal Guardian if patient is minor Date

_____
Patient's Name

Sunny Smiles Pediatric Dentistry

Acknowledgement of Receipt of Notice of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

****You May Refuse to Sign This Acknowledgement****

I have been provided with a copy of this office's Notice of Privacy Practices to review and I am aware that a copy will be made available at my request.

_____

{Please Print Patient's Name}

_____

{Signature of Patient or Legal Guardian}

_____

{Date}

Sunny Smiles Pediatric Dentistry may use or disclose protected health information for the purpose(s) of treatment, payment, collections, or health care operations. We may disclose your personal health care information to other dental and/or medical professionals relating to your treatment, payment, or health care. If you wish to authorize Sunny Smiles Pediatric Dentistry to release your personal health care information to anyone other than for the reasons above, please list below.

1. _____
2. _____
3. _____

For Office Use Only

We attempted to obtain written proof of Informed Acknowledgement of Notice of Privacy Practices, but acknowledgement could not be obtained because:

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

_____

_____

PHOTO RELEASE FORM

We love to brag about how wonderful our patients are. If able, we would love to post/share about your child's visits with us. This includes (but not limited to): our cavity free club, our patient of the day post, "peace out" cavity club, our photo booth and even pictures with the staff.

MINOR CHILD'S NAME _____

PARENT(S)_____

ADDRESS_____

PHONE_____ OR _____

EMAIL _____

_____ I DO give permission for my child's picture to be used by Sunny Smiles Pediatric Dentistry, on their website or any other publication in conjunction with Sunny Smiles programs, with the understanding that his/her name will not be used with the photo nor will he/she be identified in any other way.

_____ I DO NOT give permission for my child's picture to be used by Sunny Smiles Pediatric Dentistry.

_____

Parent/Legal Guardian Name (print)

_____

Parent/Legal Guardian Signature

_____

Date

Consent to Treat Minor Patient-Without Parent/Legal Guardian Present

If your child will only be accompanied by a parent or guardian you may refuse to sign this document

---

By law, any child under the age of 18 years old cannot be seen by a doctor without consent from a parent or legal guardian. If the minor arrives with **someone other than a parent or legal guardian**, we must have written permission from the parent or legal guardian that this person has been appointed by you to act on your behalf.

Minor's name: _____DOB:_____

For those occasions when you may not be with your child, please list those individuals who may give us consent to see your child:

Name _____

Relationship to Patient _____

Name_____

Relationship to Patient_____

LIMITATIONS: Identify any specific limitations on the kinds of Dental services for which this authorization is given. (If none, state "none")

_____

_____

□Check here if you wish to give consent for the minor to receive dental care without an accompanying adult. This consent may only apply to minors age 16 and older. This consent shall be in effect for: □Date_____ (only) □Indefinitely, until revoked by written communication

_____

AUTHORIZATION: I (parent/legal guardian name) _____ request and authorize Sunny Smiles Pediatric Dentistry and its personnel to deliver routine dental care to my child listed above as may be deemed necessary or advisable in the diagnosis and treatment of the minor child. I am also aware that the adult presenting the child is responsible for payment of the patient portion at the time of service. I have the legal right to preauthorize Sunny Smiles Pediatric Dentistry and its personnel to deliver routine dental treatment and services to my child. Routine dental care may include, but are not limited to: dental evaluation, x-rays, prophylaxis, fluoride treatments, sealants. My signature means that I have read, understand, and give my consent as stipulated above.

SIGN:_____DATE:_____