KIDS SMILE CENTER

Today's Date: _____

REGISTRATION FORM

PATIENT INFORMATION: (Please use full legal name, no nicknames please)

First Name: _____ **Last Name**: _____ **Middle Initial**: _____

Address: _____ **City:**_____

State: _____ **Zip**: _____ **Email**: _____

Home Phone #: (_____) _____ **Cell Phone:** (_____) _____

Date of Birth: _____ **Age:** _____ **Sex: Female** [ ] **Male** [ ]

Emergency Contact Name: _____ **Emergency Phone #:** (_____) _____

PARENT INFORMATION: (List person or Insured name responsible for bill - use full legal name)

Subscriber (Choose One): **Mother** _____ **Father** _____ **Self** _____

Subscriber First Name: _____ **Last Name:** _____ **Date of Birth:** _____

Company Name: _____

INSURANCE INFORMATION: (Please allow receptionist to photocopy your insurance and ID cards)

PRIMARY INSURANCE:

Policy Holder's Name: _____ **Insurance Name:** _____

Policy Holder's Social Security #: _____ **Policy Holder's DOB:** _____

Policy / ID #: _____ **Group #:** _____ **Effective Date:** _____

The above information is true to the best of my knowledge. I authorize my insurance benefits to be paid directly to the dentist/dental group. I understand that I am financially responsible for any balance. I also authorize Little Smiles Dentistry or insurance company to release any information required to process my claims.

_____ _____

Patient / Guardian Signature **Date**

KIDS SMILE CENTER

Date: _____

Medical Health History

Patient Name: _____ **Date of Birth:** _____

Name of Personal Physician: _____ **Physician's Phone #:** _____

Date of last medical visit: _____ **Current Health: Excellent** _____ **Good** _____ **Fair** _____ **Poor** _____

Do you smoke or use chewing tobacco? Yes _____ **No** _____ **If Yes, how much per day?** ____

Date of last dental visit: _____ **For:** _____

Is there anything in particular that you would like us to look at today? _____

AIDS	YES	NO
Allergies	YES	NO
If yes, what? _____		
Anemia	YES	NO
Arthritis	YES	NO
Asthma	YES	NO
Blood Disease	YES	NO
Cancer	YES	NO
Diabetes	YES	NO
Dizziness	YES	NO
Epilepsy	YES	NO
Fainting	YES	NO
Glaucoma	YES	NO
Hay Fever	YES	NO
Heart Disease	YES	NO
Heart Murmur	YES	NO
Hepatitis	YES	NO
Jaundice	YES	NO
Pacemaker	YES	NO

Currently Pregnant	YES	NO
If yes, due date? _____		
Head Injuries	YES	NO
Respiratory Issues	YES	NO
Sinus Problems	YES	NO
Stroke	YES	NO
Tumors	YES	NO
Latex Allergy	YES	NO
Venereal Disease	YES	NO
Codeine Allergy	YES	NO
Penicillin Allergy	YES	NO
Sulfa Allergy	YES	NO
Other Allergies	YES	NO
If yes, what? _____		
Radiation Treatment	YES	NO
Rheumatism	YES	NO
Stomach Problems	YES	NO
Tuberculosis	YES	NO
Taken Fen-Phen	YES	NO

Are you taking any medications? If so, what?

_____

_____

_____

Do you have any disease or medical problems NOT listed on this form? If so, what is it?

_____

_____

Have you or your family been diagnosed with COVID-19 caused by the novel coronavirus?

_____

_____

To the best of my knowledge, I have answered every question completely and accurately. I will inform my dentist of any change in my health and/or medication.

_____ _____

Patient / Guardian's Signature **Date**

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INFORM CONSENT FOR XRAYS, EXAM AND CLEANING

I authorized the Dentist and Staff to perform an examination, which may include xrays. If diagnosed with prophy (regular cleaning), I authorize to have the procedure done.

CHANGES IN TREATMENT PLAN: I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changes and additions as necessary.

INFORMED CONSENT FOR RADIOGRAPHS (X-RAYS): This office follows the guidelines of the American Dental Association and recommends that FULL MOUTH XRAYS (FMX) BE TAKEN ONCE EVERY 3 TO 5 YEARS and BITE WING XRAYS twice a year for caries active patients and once annually for routine cases. Current Xrays will be necessary before any diagnosis can be finalized. NO TEETH WILL BE EXTRACTED without a current PA (periapical xray showing the root and surrounding bone and soft tissue). No fillings will be placed without current bitewings and/or PAs of the tooth. NO EXCEPTIONS.

CHILDREN AND ADULTS: If any decay or dental infection (abscess) is obvious on visual inspection, xrays will be necessary to assess the extent of damage to the tooth structure. If your child is uncooperative, you will be referred to a pediatric dentist for treatment. Bite-wings and occlusal films are recommended for school age children 5 yrs and up. Bite-wing xrays may be suggested at age 3.5 to 4 yrs if there is no spacing between the teeth and if we suspect caries.

PREGNANT WOMEN: XRAYS WILL BE AVOIDED UNLESS IT IS AN EMERGENCY. Please inform this office if you think you are pregnant and xrays will be postponed. XRAYS are used to diagnose 1) extent of bone loss associated with PERIODONTAL DISEASE 2) interproximal caries--decay in between the teeth 3) pathology of pulp 4) integrity of root canal fillings 5) verify tooth or root structure 6) supernumerary teeth. Impacted teeth 7) pathologic root resorption 8) third molar location and position 9) bone pathology 10) need for interceptive orthopedic/orthodontic treatment II) what is normal for you. This will become important if you ever have trauma to your face and teeth due to an auto/ bike accident or sports injury for example.

ROUTINE CLEANING: Treatment involves removing the bacterial substance known as plaque, which is the principal cause of periodontal disease and calculus, which is an accumulation of hard deposits on the tooth above the gingival margin. I understand that my gums may bleed or swell and I may experience moderate discomfort for several hours. There may be slight soreness for a few days. I will notify the office if conditions persist beyond a few days. I understand that as my gum tissues heal, they may shrink somewhat, exposing some of the root surface. This could make my teeth more sensitive to hot or cold. I understand that I may receive a local anesthetic and/or other medication.

Patient or Guardian Signature _____ Date_____

KIDS SMILE CENTER

NO SHOW/MISSED APPOINTMENT POLICY FORM

Our goal is to provide quality individualized dental care in a timely manner. Missed appointments and late cancellations inconvenience those individuals who need access to care. Our office policy regarding missed appointments enables us to better utilize available appointments for our patients in need of dental care.

CANCELLATION OF AN APPOINTMENT: In order to be respectful of the needs of other patients, please be courteous and call us promptly if you are unable to show up for an appointment. This time will be reallocated to someone who is in need of treatment. If it is necessary to cancel your scheduled appointment, we ask that you call at least 24 hours in advance. Please call (972) 537-5730. If you do not reach the receptionist, you may leave a detailed message including your phone number. We will return your call as soon as possible and give you the next available appointment time. Appointments are in high demand and your early cancellation will give another patient the opportunity to be treated.

MISSED APPOINTMENT POLICY: A failure to be present at the time of a scheduled appointment will be recorded in your medical record as a "Missed Appointment." Cancelling with less than 24 hours notice will also be recorded as a "Missed Appointment." We reserve the right to charge for a “Missed Appointment”.

There is a charge of $25 PER HOUR for not showing up for scheduled appointments and cancelling with less than 24 hours notice. *Repeated cancellations or missed appointments will result in loss of future appointment privileges. Every patient in our practice receives this unique reservation. When your appointment is made, a time is reserved, your materials are ordered, and we make special arrangements to be ready for your visit.

CONTINUED MISSED APPOINTMENTS: Dismissal from our Dental Practice.

TREATMENT DEPOSIT POLICY: When our office books your treatment appointment, we are setting aside a dedicated chair and time slot just for you. We collect a non-refundable deposit in order to reserve the chair time. We only ask that if you must reschedule your appointment, that you please provide us with at least 24 hours notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept. The entirety of the appointment deposit goes towards the cost of treatment, unless the appointment is broken with less than 24 hour notice, in which the "Missed Appointment Policy" charge will be deducted from the deposit.

Signature: _____ **Date:** _____

KIDS SMILE CENTER

Financial Responsibility Form

Patient Name: _____ **Date of Birth:** _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Telephone: (_____) _____

If patient is under the age of 18, name of the individual who is financially responsible for Patient,

_____

If you have dental insurance, we will file the claims for you, as a complimentary service. It is very important that the correct insurance information is provided at the time of the patient's appointment. If this information changes, it is the patient's responsibility to update Little Smiles Dentistry at the earliest convenience. While we do our best to verify dental benefits prior to your first appointment, this does not guarantee coverage or payments to Little Smiles Dentistry. We do accept payments from the dental insurance companies; however, we are not contacted with them. It is contact between you, your employer and the insurance company.

If requested, we will provide you with a verbal **ESTIMATE** of your out of pocket expense for any treatment planned by the doctor. However, please understand that these are strictly **ESTIMATES** and are not a guarantee that your insurance company will reimburse us/you according to these estimates.

Please note that any difference in payment from your insurance company and your account balance is your responsibility. While the filing of insurance claims is a courtesy that we extend to all of our patients, all charges are your responsibility from the date the services are rendered. If difficulty arise with payment from the insurance company, we will ask that you contact your carrier to rectify the problem. All expected insurance balances remaining unpaid after 90 days from the date of services becomes the immediate responsibility of the patient and/or account holder.

Payment for co-pays and/or deductibles is due at the time services are provided.

Any balance older than 90 days will be subject to interest charges of 1.5% per month, from the date of service, until the account is paid in full. If a payment has not been received on the account during the 90 days, the account risks being sent to a collection agency or an attorney, additional collection fees will be applied to any unpaid balance. Any attorney or collections fees incurred due to delinquency in payment or collection efforts will also be charged to you, including court cost and fees. Any personal check returned unpaid or with non-sufficient (NSF) will incur a $30 NSF check fee and may also subject to a court costs and attorney fees.

I acknowledge having read this Financial Responsibility Form in its entirety and agreed to be bound by all the terms and conditions herein.

Patient/Guardian Signature: _____ **Date:** _____

Notice of Privacy Practice

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients' Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office, or going to our website.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatment, payment or health care operations.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent, in writing, signed by you. However, such revocation shall not affect any disclosures have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

The Patient understands that:

- Protected health information may be disclosed or used for treatment, payment or health care operations.
- The Practice has a Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The Patient has the right to restrict the uses of their information.
- The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
- The Practice may condition treatment upon execution of this Consent. No insurance can be billed on the patient's behalf without this signed HIPAA consent form, therefore same day of service payment in full for any services will be required.

Patient/Guardian Signature: _____ **Date:** _____