Drs. McIntyre & Whiting—Smiles for Life

Child Patient Information

Today's Date _____ Patient Name (last, first, middle initial) _____

Preferred Name_____ Gender _____ Birthdate _____

SSN_____ School _____ Grade _____

Prefer contact by: ☐ email ☐ phone call ☐ text

How did you hear about us? _____

Home Phone (____) _____ Street Address _____

City _____ State _____ Zip _____

Parent/Guardian's Cell # (____) _____ Parent/Guardian's Work # (____) _____

Parent/Guardian's Email Address _____

Additional Information

Mother's Name _____ Father's Name _____

Mother's Employer _____ Father's Employer _____

Mother's Birthdate _____ Father's Birthdate _____

Mother's SSN _____ Father's SSN _____

Mother's Phone # _____ Father's Phone # _____

Person financially responsible (if other than parent) _____ Relationship to child _____

What is child's favorite: Sport? _____ Toy? _____

Hobby? _____ Fictional character? _____

Dental Insurance Information

Does the child have dental insurance? ☐ Yes ☐ No

Subscriber's Name_____ Insurance Co._____

Relationship to Patient_____ ID #_____

Subscriber's Birthdate_____ Policy #_____

Subscriber's SSN_____ Group #_____

Is this through an employer? ☐ Yes ☐ No

Employer:_____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (Name of Insurance Company[ies]) and assign directly to Smiles for Life all insurance benefits, if any, otherwise payable to me for services rendered. **I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.**

The above-mentioned dentist may use my health care information and may disclose such information to the above-mentioned Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative

Please print name of Patient, Parent, Guardian or Personal Representative

Drs. McIntyre & Whiting—Smiles for Life

Child Dental History

Date of last visit to a dentist _____ For what service? _____

	YES	NO
Has child complained about dental problems?	☐	☐
Any unhappy dental experiences?	☐	☐
Any injuries to mouth, teeth or head?	☐	☐
Any mouth habits? (thumb-sucking, nail-biting, mouth breathing, nursing bottle habits, pacifier, etc.)	☐	☐
Any unusual speech habits?	☐	☐
Any lost teeth?	☐	☐
Have missing teeth been replaced?	☐	☐
Orthodontic appliances worn now or ever?	☐	☐

	YES	NO
Does your child brush teeth daily?	☐	☐
Do you assist your child with tooth brushing?	☐	☐
How often? _____		
Is dental floss used?	☐	☐
How often? _____		
Are disclosing tablets used?	☐	☐
Is fluoride taken in any form?	☐	☐
Do you desire complete dental service for the child?	☐	☐

How is your child's attitude toward dentistry?

_____

_____

_____

Child Health History

Child's Physician _____ Phone _____

Date of last physical examination _____ Results _____

	YES	NO
Is child under care of physician now?	☐	☐
Is child receiving any medication or drugs?	☐	☐
Is there any excessive bleeding when cut?	☐	☐
Has child ever been hospitalized? Had surgery?	☐	☐
Is there any allergy to penicillin or other drugs?	☐	☐
Any other allergies? (food, pollen, animals, dust, other)	☐	☐
Does child have good physical coordination?	☐	☐
Are there any emotional problems?	☐	☐

Has child had any history or difficulty with any of the following:

___ Anemia	___ Epilepsy	___ Measles
___ Asthma	___ Fainting	___ Mononucleosis
___ Bladder	___ Hearing	___ Mumps
___ Cerebral Palsy	___ Heart	___ Rheumatic fever
___ Chicken Pox	___ Kidney	___ Thyroid
___ Chronic Sinus	___ Liver	___ Tuberculosis
___ Convulsions	___ Malignancies	___ Veneral disease
___ Diabetes	___ Mastoid	___ Other

Please describe any current medical treatment including drugs, pending surgery, recent injuries or any other information of which we should be aware.

_____

_____

_____

_____

_____

_____

Drs. McIntyre, Whiting, & Rockey—Smiles for Life

Acknowledgement of Receipt of Notice of Privacy Practices: Child Patient

TO THE PATIENT'S PARENT OR GUARDIAN--PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

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 the child's protected health information and of other important matters about their protected health information. A copy of our Notice is posted at the front desk and a copy can be made available to you by request. 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 the child's protected health information that we maintain.

You may obtain a new copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Becky McIntyre (Office Manager) **Telephone:** 540-828-2312 **Fax:** 540-828-2857

Email: smiles@smilesforlifeonline.com **Address:** 115 Oakwood Drive, Bridgewater VA 22812

This acknowledgement page will be retained in the patient's record.

I request that the following have access to the child's Personal Health Information:

Name _____ Full Access or Partial Access (Circle One)

If partial, I grant this person access to my: ☐ Health Information ☐ Treatment Information ☐ Financial Information

Name _____ Full Access or Partial Access (Circle One)

If partial, I grant this person access to my: ☐ Health Information ☐ Treatment Information ☐ Financial Information

Name _____ Full Access or Partial Access (Circle One)

If partial, I grant this person access to my: ☐ Health Information ☐ Treatment Information ☐ Financial Information

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

Patient's Name _____

Parent/Guardian's Signature _____ Date _____

Right to Revoke: You 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 the child or to continue treating them if you revoke this Consent.

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of the child's protected health information for treatment, payment activities, and healthcare operations. I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I understand that you may decline to treat or to continue to treat the child after I have revoked my Consent.

Signature: _____ Date: _____