

Patient information

Patient Information

First name _____ Last name _____ Preferred name _____

Date of birth _____ Female Male

Whom may we thank for referring you to our office? _____

Parent or Guardian One (Primary Contact)

Name _____ Mobile phone _____

Home phone _____ Email address _____

Mailing address _____ City _____ State _____ Zip _____

Social security number _____ Date of birth _____

Driver's license number _____

Place of employment _____

Parent or Guardian Two (If Applicable)

Name _____ Mobile phone _____

Home phone _____ Email address _____

Mailing address _____ City _____ State _____ Zip _____

Social security number _____ Date of birth _____

Driver's license number _____

Place of employment _____

Emergency Contact

Name _____ Phone _____

Mailing address _____ City _____ State _____ Zip _____

I acknowledge that the above information is current and accurate.

Parent or Guardian Signature _____ Date _____

Patient health history

Patient Information

Child's name _____ Date _____

Date of birth _____ Current weight ((lbs.)) _____

So that we may know and better understand your child, and be better prepared to render the best possible health service, it is requested that you complete the following:

Dental History

Date of last dental exam _____ Date of last dental x-rays _____

Has your child had dental treatment elsewhere? _____

1. What was his or her reaction to prior dental treatment? _____

2. Does your child have any dental complaints? _____ If yes, how long? _____

3. Is there anything you would like us to know so that we can better care for your child? _____

Medical History

Has your child ever had:

- | | |
|--|---|
| <input type="radio"/> Abnormal Heart Condition | <input type="radio"/> Genetic Disorder Syndrome |
| <input type="radio"/> ADD/ADHD | <input type="radio"/> Intestinal/Stomach Problems |
| <input type="radio"/> Asthma/Respiratory Disease | <input type="radio"/> Kidney Problems |
| <input type="radio"/> Autism Spectrum Disorder | <input type="radio"/> Liver Problems |
| <input type="radio"/> Blood Disorders ((ex: Anemia, Hemophilia, HIV, Hepatitis)) | <input type="radio"/> Mental, Emotional or Development Delays |
| <input type="radio"/> Cancer | <input type="radio"/> Neurologic Disorder (ex: CP, Seizures) |
| <input type="radio"/> Diabetes | <input type="radio"/> Any Surgical History |

Is your child allergic to:

- | | | |
|---------------------------------------|---|-------------------|
| <input type="radio"/> Penicillin | <input type="radio"/> Frequent Headaches | Relieved by _____ |
| <input type="radio"/> Sulfa | <input type="radio"/> TMJ (Jaw Joint Dysfunction) | Relieved by _____ |
| <input type="radio"/> Any Medication? | <input type="radio"/> Congenital Birth Defects | Relieved by _____ |

Has your child ever had a local anesthetic?

- No Yes

Is your child current on immunizations?

- No Yes

Does your child suck a finger, thumb or pacifier?

- No Yes Relieved by _____

Does your child sleep with a nursing bottle?

- No Yes Relieved by _____

Date of last physical exam _____

Does your child have any special health care needs? _____

Is your child taking any medication? _____ If so, what? _____

Name of physician _____ Physician phone _____

Physician address _____

May we contact your child's physician for additional information, if necessary? _____

Briefly describe your child's personality/temperment _____

Insurance verification



Patient Information

First name _____ Last name _____ Date of birth _____

Insurance company name _____

Phone _____ Group # _____

Mailing address _____ City _____ State _____ Zip _____

Subscriber name (Employee) _____ Date of birth (Employee) _____

Subscriber ID/SS# _____

Employer _____

Acknowledgement of privacy practices



I acknowledge that a copy of the Notice of Privacy Practices for the office of Southmoor Pediatric Dentistry is available to me upon request. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or the performance of office health care operations. The Notice of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information.

Southmoor Pediatric Dentistry reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. If privacy practices change, a copy of the revised Notice of Privacy Practices may be provided to me upon request.

I, _____, authorize Southmoor Pediatric Dentistry to disclose my protected health information to only the persons indicated below.

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Name _____ Relationship to Patient _____

Signature of Patient or Guardian _____ Date _____

Financial policy



In an effort to provide the best service to you and your children, we try to provide a treatment plan which fits your timetable and budget. Payment for professional services is due at the time dental treatment is provided. We accept cash, personal checks, and most major credit cards.

We file dental insurance as a courtesy to our patients. If we have received all your insurance information on the day of the appointment, we will be happy to file your claim for you. You must be familiar with your insurance benefits as most insurance agreements require a patient responsibility for dental services. Your estimated patient portion is due at each visit. You are responsible for any balance on your account after 30 days, regardless of any outstanding insurance claims. We will be glad to issue a refund if your insurance company pays any portion after you have paid your bill. We can provide you with a claim form if you need to follow up with your insurance carrier, but please remember that our financial relationship is with you and we are not responsible for how your insurance company handles its claims or for what benefits they pay on a claim.

A 1.5% finance charge (18% annually) will be added to any balance over 90 days.

I have read and accept the above Financial Policy and agree to the terms therein.

Parent or Guardian Signature

Today's date

Media consent and release



SouthmoorKids.com

Authorization to release orthodontic treatment information

Photos and other digital media that reflect your child's treatment success and positive experience can help others decide that Southmoor Pediatric Dentistry is the right choice for their child's dental care.

- I hereby consent to Southmoor Pediatric Dentistry's and its affiliates' use of photographs and media related to my/ my minor child's treatment, along with details regarding the related dental services, for marketing and advertising purposes. This consent form is optional and I understand that Southmoor Pediatric Dentistry will not condition treatment on whether I sign this authorization form.

I authorize Southmoor Pediatric Dentistry and its affiliates to use photograph(s), video(s), and/or media representation(s) (whether such material was provided by me or produced by Southmoor Pediatric Dentistry) related to my or my minor child's care. I understand that these materials might be used in advertisements, office displays, online (e.g., websites, Facebook, Instagram, etc.), and in any other format that Southmoor Pediatric Dentistry chooses. I release the photographer, Southmoor Pediatric Dentistry, their affiliates, employees, agents, and designees from liability for any violation of any personal or proprietary right I or the patient may have in connection with such use. I waive any rights to inspect or approve promotional materials which include these materials related to my treatment.

This authorization shall expire upon completion of all Southmoor Pediatric Dentistry's promotional activities. I understand that I may revoke this authorization by sending a written request for revocation to Southmoor Pediatric Dentistry's Privacy Officer. If I revoke this authorization, Southmoor Pediatric Dentistry will no longer use or disclose my medical information for the reasons covered by this authorization, except to the extent it has already relied upon this authorization (for example, if my photographs are already being used in an ongoing advertising campaign). I understand that when Southmoor Pediatric Dentistry discloses information pursuant to this authorization, the information may no longer be protected by federal or state privacy rules and may be subject to re-disclosure by the recipient of the information.

- I do not consent to the use of these materials of myself or the listed patient.

Patient information

Patient name _____ Date of birth _____

Legal guardian full name (if patient is a minor) _____

Responsible party signature _____ Date _____