SMILE STARS
PEDIATRIC DENTISTRY & ORTHODONTICS

Patient Information		
Name:		
Date of Birth:	SSN:	Phone:
Current Address:		
City:	State:	ZIP Code:
Current School:		
Male or Female	Child's Physician:	ZIP Code:
How did you hear about us?		

Medical Questionnaire

Please check any information that is pertinent to your child

☐ Abnormal Bleeding	☐ Allergies	☐ Anemia
☐ Arthritis	☐ Asthma	☐ Autism
☐ Brain Injury	☐ Bronchitis	☐ Convulsions/Seizures
☐ Cancer	☐ Cerebral Palsy	☐ Cleft Lip/Palate
☐ Developmental Delay	☐ Diabetes	☐ Eye Problems
☐ Fainting	☐ Hearing Loss	☐ Hepatitis
☐ Hemophilia	☐ Heart Disease	☐ Heart Murmur
☐ HIV/AIDS	☐ Mental Retardation	☐ Kidney Disease
☐ Liver Disease	☐ Respiratory Problems	☐ Rheumatic Fever
☐ Sinus Problems	☐ Skin Rashes	☐ Scoliosis

Other _____

	Yes	No
Is your child currently under the care of a physician for any medical problems? If yes, for what? _____	_____	_____
Is your child currently taking any medicine? If yes, what? _____	_____	_____
Is your child allergic to any food or medicine? If yes, what? _____	_____	_____
Has your child ever been hospitalized or had surgery? If yes, for what? _____	_____	_____
Has your child ever received general anesthesia or sedation? If yes, when? _____ Any unfavorable reaction? _____	_____	_____

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

Please rate your child's current physical health**:** **Good** **Fair** **Poor**

Dental History:

Has your child been to the dentist before? Yes No

If yes, previous dentist and date of last visit: _____

Are there any dental problems that you are aware of? Yes No

If yes, please explain: _____

Has your child experienced any unfavorable reaction to medical or dental care? Yes No

If yes, please explain: _____

How do you think your child will react to the dentist? _____

How often does your child brush? _____Is it supervised? _____ By Whom? _____

Does your child floss? Yes No Is your child receiving fluoride in water or vitamins? Yes No

Does your child have any of the following habits:

- ☐ Thumb/Finger Sucking
- ☐ Sippy Cup
- ☐ Mouth Breathing
- ☐ Pacifier Sucking
- ☐ Nail Biting
- ☐ Grinding/Clenching
- ☐ Bottle/Breast Feeding
- ☐ Lip Biting/Sucking
- ☐ Other _____

Reason for Today's Visit:

Cleaning and Examination: _____ Tooth pain: _____ Referred for dental tx: _____

2nd opinion: _____ Orthodontic evaluation: _____ Other:_____

Previous dentist: _____

Family Information

Father's full name:		
Mailing address: (if different from patient)		DL #:
Occupation:	Employer:	D.O.B:
SS #:	Work Phone:	Cell Phone:
Mother's full name:		
Mailing Address: (If different from patient)		DL #:
Occupation:	Employer:	D.O.B:
SS #:	Work Phone:	Cell Phone:
Email address:		

Emergency Contact			
Name:	Relationship to Patient:		
Address:			
City:	State:	ZIP Code:	Phone:

Insurance and Financial Responsibility		
Subscribers Name:		
Insured Date of Birth:	SSN:	Group or Policy #:
Name of Insurance Company:		
Relationship to Patient:	Employed By:	Ok to File?

Consent of Care:

We are so humbled that you have chosen to be a part of the Smile Stars family by placing the trust and confidence into our office. You and your child's needs are our number one priority and we hope we exceed your expectations. Below is consenting to treat your child at each visit after thorough explanation of services deemed and that you have filled this out to the best of your knowledge.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I hereby authorize the dentist and staff to use such measures deemed necessary in their professional judgment to render the best dental treatment for my child. I further authorize the taking of X-rays or photographs of my child or child's teeth for diagnostic purposes and topical fluoride treatment at each routine cleaning. I understand that payment is expected for service rendered at the time of service. I also understand that Smile Stars files insurance claims electronically. Finally, I understand my privacy rights and how my information can be used.

As a courtesy, our office will be happy to file any new and existing patient insurance claims.
We may accept assignment of insurance benefits. However, we do require all co-pays and deductibles to be paid at time of service. The balance is your responsibility whether your insurance company pays or not. We will be happy to bill your insurance with correct insurance information and an original claim form. **If your insurance has not paid your account within 45 days, the balance will become your full responsibility.** Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under your insurance.

Signature: _____ **Relationship to child:** _____ **Date:**_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices

Please Print Childs Name: _____ Patients Date of Birth: _____

Parents Signature: _____ Date: _____