

WELCOME to
South Florida Dentistry for Children & Orthodontics, P.A.

PEDIATRIC DENTISTS

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We would like to welcome you and your family to our office. As a dedicated dental team, we are committed to providing exceptional care and exceeding your expectations. We strive to make each patient's experience special, pleasant and educational while caring for them as we would our own family members. Our practice is based on preventative care that will enable your child to have a beautiful smile that lasts a lifetime.

The greatest compliment our patients can give is the referral of their friends and loved ones. Thank you for your trust.

PLEASE PRINT

TELL US ABOUT YOUR CHILD

Today's Date: _____
 Child's Name _____
 Nickname: _____ Sex: _____
 Child's birthdate: _____ Age: _____
 School: _____ Grade: _____
 Child's home Address: _____
 City _____ State _____ Zip Code _____
 Home Phone: _____
 Name / Age of siblings: _____
 Previous Dentist: _____
 Last Visit Date: _____
 Who may we thank for referring you? _____

IN CASE OF EMERGENCY CONTACT:

Name: _____
 WK#: _____ HM#: _____
 Relationship: _____

MOTHER'S INFORMATION (Stepmother ___ Guardian ___)

Name: _____
 Address: _____
 City _____ ST _____ Zip _____
 HM # _____ CELL # _____
 Email: _____
 Employer _____ WK # _____
 Occupation: _____
 SS# _____ DL# _____
 Insurance ID #: _____

FATHERS INFORMATION (Stepfather ___ Guardian ___)

Name: _____
 Address: _____
 City _____ ST _____ Zip _____
 HM # _____ CELL # _____
 Email: _____
 Employer _____ WK # _____
 Occupation: _____
 SS# _____ DL# _____
 Insurance ID #: _____

PERSON RESPONSIBLE FOR ACCOUNT

Name: _____
 Relationship to Patient: _____
 Billing Address (if different from patient): _____
 City _____ State _____ Zip Code _____

PRIMARY DENTAL INSURANCE

Insurance co. Name: _____
 Insurance co. Address _____
 Insurance Co. Phone # _____
 Group# (Plan, Local or Policy 3) _____
 Insured's Name: _____
 Relationship to Patient: _____
 Insured's B-day: ___/___/___ ID# or SS# _____
 Insured Employer: _____

SECONDARY DENTAL INSURANCE

Insurance co. Name: _____
 Insurance co. Address _____
 Insurance Co. Phone # _____
 Group# (Plan, Local or Policy 3) _____
 Insured's Name: _____
 Relationship to Patient: _____
 Insured's B-day: ___/___/___ ID# or SS# _____
 Insured Employer: _____

WHY DID YOU BRING THE CHILD TO THE DENTIST TODAY? _____

Has the child ever had a serious/difficult problem associated with previous dental work? Yes No

Please explain _____

Has the child ever had any pain/tenderness in their jaw joint (TMJ/TMD)? Yes No

Does the child brush their teeth daily? Yes No

Floss their teeth daily? Yes No

Fluoride taken? Yes No

Child's Physician _____

Phone# _____

Is the child currently under the care of a physician?
 Yes No

Please describe the child's current physical health _____

Please list all drugs the child is currently taking _____

Please list all drugs that the child is allergic to _____

HAS THE CHILD EVER HAD ANY OF THE FOLLOWING MEDICAL PROBLEMS?

- | | | | | | |
|---|---|-------------------|---|---|--------------------------|
| Y | N | Heart Murmur | Y | N | Congenital Heart Defect |
| Y | N | Cancer | Y | N | Convulsions / Epilepsy |
| Y | N | Diabetes | Y | N | Abnormal Bleeding |
| Y | N | Rheumatic Fever | Y | N | Hearing Impairment |
| Y | N | HIV+ / Aids | Y | N | Any Operations |
| Y | N | Hemophilia | Y | N | Any stays in a hospital |
| Y | N | Asthma | Y | N | Kidney / Liver Problems |
| Y | N | Hepatitis | Y | N | Handicaps / Disabilities |
| Y | N | Tuberculosis (TB) | Y | N | Allergies |

Please discuss any serious medical problems that the child has had: _____

HAS THE CHILD HAD OR HAVE ANY OF THE FOLLOWING HABITS?

- | | | |
|---|---|------------------------|
| Y | N | Pacifier |
| Y | N | Thumb / Finger Sucking |
| Y | N | Lip Sucking / Biting |
| Y | N | Nail Biting |
| Y | N | Nursing Bottle Habits |
| Y | N | Snoring |
| Y | N | Grinding |

Our office is committed to meeting or exceeding the standards of infection mandated by OSHA, the CDC and the ADA

Please read and sign the following responsibility and consent for treatment, payment and health care operations.

To the best of my knowledge, the above information is complete and correct.

I understand that this information may be disclosed in treatment, for payment, and in normal healthcare operations.

I understand that I am responsible for any financial obligation incurred for services provided and accept full responsibility for this account. Insurance is processed as a courtesy to patients. It is my obligation to understand my insurance coverage.

I authorize and request my insurance company pay directly to the dentist or dental group, insurance benefits otherwise payable to me. I understand that any insurance estimate given by this office is not a guarantee of actual insurance payment or coverage.

Any insurance claim not paid in full in 60 days will become my responsibility at that time.

Payment is due when services are rendered.

If at any time there is a change of insurance, I will notify your business office so you may update my account.

I understand that if my account is forwarded for collection, I will be responsible for the balance and all collection fees.

I will be informed of all services and their estimated cost before any service are rendered.

_____ Responsible Party Signature (and relationship, if for child) _____ Date _____

_____ Responsible Party Name (Please Print) _____