PATIENT INFORMATION

Patient Name: ____ DOB: _____/_____/_____ Age: ______
Last, First, MI

Phone (Home): (_____) _____________ (Cell): (_____) ______________ Email: _______________________________

Address: _____________________________________ ☐ I would like to receive **phone call** confirmations

_____________________________________ ☐ I would like to receive **emailed** confirmations

_____________________________________ ☐ I would like to receive **text** confirmations

RESPONSIBLE PARTY

Name of Responsible Party: ____ DOB: _____/_____/_____
Last, First, MI

Address (if different than above):

__________________________________ Relationship to Patient: _____________________

__________________________________ ☐ Married ☐ Single

__________________________________ Who Referred you to our office? _________________________

MEDICAL HISTORY

Date of Last Dental Visit: _____/_____/_____ ☐ **My child requires Premedication Antibiotics**

Reason for this visit: ____

Is your child Allergic to or have they had reactions to:

Y	N	
☐	☐	Antibiotics (penicillin, etc.)
☐	☐	Sulfa Drugs
☐	☐	Latex/Rubber
☐	☐	Metals (Nickel, etc.)
☐	☐	Seasonal Allergies/ Pollen
☐	☐	Local Anesthetics
☐	☐	Barbiturates, Sedatives, Sleeping Pills
		Other: _________________________
		_________________________

Does your child have any of the following Conditions?

Y	N		Y	N	
☐	☐	Heart Trouble/ Surgery	☐	☐	ADHD
☐	☐	Immune Disease	☐	☐	Autism/ Spectrum Disorder
☐	☐	Kidney/ Liver Disease			
☐	☐	Diabetes	☐	☐	Mental Disorders
☐	☐	Bone/ Joint Issues	☐	☐	Anxiety
☐	☐	Cancer/ Malignancies	☐	☐	Depression
☐	☐	Asthma			
☐	☐	Blood Disorders			
		Other: ____________________________________			

Is your child under medical care now? ☐ NO ☐ YES: ____

Has your child ever been hospitalized or had an operation? ☐ NO ☐ YES: ______________________________

Is your child taking any medications? ☐ NO ☐ YES: ____

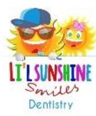
Does your child have any mouth habits? (thumb sucking, lip/cheek biting, etc.) ☐ NO ☐ YES: _______________

Has your child experienced a “negative” dental or medical experience? ☐ NO ☐ YES: ___________________

Is there anything else you would like to add to your child’s medical or dental history?

____

____



INSURANCE INFORMATION

IF YOUR CHILD HAS MEDICAID: *(MCNA, Liberty/Staywell)*

Child's Name as it is spelled on insurance card: ____
Last, First, MI

Child's DOB: _____/_____/_____

Insurance Name: _________________________________

Insurance Phone number: (_____) ____________________

Has your child used this insurance at another Dental office? NO YES, When? _____/_____/_____

IF YOUR CHILD IS A DEPENDENT UNDER A PPO/HMO: *(Aetna, Delta Dental, Metlife, Cigna, etc.))*

Subscriber/Policy Holder's Name: ____
Last, First, MI

Subscriber's DOB: _____/_____/_____ Subscriber's SSN: _____ - ____- _____

Employer Name: ____

Insurance Name: ____

Insurance Phone Number: (_____) ____________________

Subscriber ID/Member Number: ____

Group Name/ Group Number: ________________________

*****Please provide the front desk with all insurance cards for record.**

*****If using a primary and secondary, please inform the front desk as well**.

To the best of my knowledge, all the preceding answers and information provided are true and correct. If my child ever has any change to his/her health, I will inform the doctors at the next appointment without fail.

____ Date: _____/_____/_____
Signature of Legal Parent/ Guardian

____ Date: _____/_____/_____
Signature of Treating Dentist/ Provider

Welcome To Our Office!

We believe in creating vibrant and healthy smiles using the most advanced quality dentistry to exceed our patient's expectations
Beginning with the overall health of your child's mouth, we can provide your child with the smiles he or she needs.
We would like to provide you with information to make our patient's experience more comfortable.

Office Hours:

Monday	9:00AM – 4:00PM
Tuesday	9:00AM – 4:00PM
Wednesday	9:00AM – 4:00PM
Thursday	8:30AM – 4:30PM
Friday	8:30AM – 4:30PM

Initial

☐ ☺ One Parent/ Guardian is allowed to accompany child during the 1st visit.

☐ ☺ Only the child with appointment may enter the hygiene/treatment area. Other children must wait in the waiting room.

☐ ☺ Due to Infection control protocols, we only allow the patient in the treatment room. In our experience, children tend to listen better when parents/ guardians are not present.

☐ ☺ **NO** cell phones permitted beyond office waiting room. Please respect our patient's privacy. **NO** photos, selfies, or social media is allowed without consent and supervision of a staff member.

☐ ☺ If your child's appointment is not verbally confirmed the **24 hours prior**, your appointment will be removed from the schedule.

☐ ☺ Payment in full is expected prior to / during time of service. We accept Visa, Mastercard, Discover, and American Express. We also accept Care Credit and check payments.

☐ ☺ If you are 15 minutes late you may be asked to reschedule your appointment.

☐ ☺ We will file your Insurance and accept assignment of benefits. Please note, insurance does not guarantee payment on any claims, and you will be responsible for any balance not paid by the insurance.

☐ ☺ We do require for Responsible Party/ Patient 18 years old or over to present ID. We do require Responisble party to stay in office during the **ENTIRE** duration of appointment.

☐ ☺ We do have a 3 strike No show policy. If you are unable to make your planned appointment we prefer rescheduling that appointment for a better time, rather than obligating that unfilled time in our schedule. A **$30** cancellation fee may be collected for No call/No show.

☐ ☺ Our office confirms **3 different ways**: Text, Email, and traditional Phone calls. If you **DO NOT** receive a confirmation notice at least **1 day prior** to your appointment, please call the office and make sure you are still on the schedule. Technology is not perfect, and appointments can (rarely) get kicked off.

With the contact information that I presented to Li'l Sunshine Smiles Dentistry: I authorize Li'l Sunshine Smiles Dentistry to contact me regarding my child's past, present, or future treatment: via phone, E-mail, voicemail, mail etc. (Commercial). If contact information changes, please notify front staff.

HIPAA PRIVACY POLICY &

LIMITED POWER OF ATTORNEY

If a friend/family member other than the legal parent/guardian brings your child to an appointment, that individual must be on the permission form below with ID. If these steps are not followed, appointment may be asked to be rescheduled. This is to protect the patient and their information.

By signing this form, you acknowledge that you have seen, read, and understood all of the HIPAA Privacy Policy, and also authorize Lil Sunshine Smiles Dentistry to discuss my information with the following persons listed below. **Information will only be disclosed to authorized persons**.

I, ________________________________, authorize the person(s) listed below to accompany my child to his/her dental appointments, and make necessary dental decisions in the best interest of my child at their dental visits until further notice. Further notarization is required if authorized person is someone other than Legal Parent/ Legal Guardian.

NAME	RELATIONSHIP
______________________________	__________________________
______________________________	__________________________
______________________________	__________________________

☐ I **DO NOT** authorize anyone other than myself to discuss and make medical decisions for my child. No other legal adult will be attending appointments with my child. *(only check if above is blank)*

Legal Parent/Guardian Signature: ______________________________

Date Authorized: ____/_____/_____

Legal parents/guardians may revoke any authorizations to any persons listed above at any time.

I hereby Revoke any authorized persons : ____
Signature of legal parent/guardian

Revoked Date: _____/_____/_____

WE WILL PROVIDE A COPY OF THE HIPAA PRIVACY POLICY UPON REQUEST