WELCOME KIDS!

We would like to welcome your child to It's A Small World. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventative care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!

www.itsasmallworlddentistry.com

IT'S A SMALL WORLD
CHILDREN'S DENTISTRY

Tell Us About Your Child

Today's Date: _____

Child's Name: _____
Last First MI

Child's Birthdate: ___/___/_____ Child's Age: _____

Nickname: _____ ☐ Male ☐Female

School: _____ Grade: _____

Child's Home #: _____

Child's Home Address: _____
#Apt. /Condo

_____
City State Zip Code

General Information

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have legal custody of the child? ☐ Yes ☐ No

Who may we thank for referring you? _____

Other Siblings that attend It's A Small World?

_____

Parent's Information

Person responsible for Account: _____

☐Mother/Father ☐Step Mother/Father ☐Guardian

Name: _____ DOB _____
Address (if different than Child's):

_____
#Apt. /Condo

_____
City State Zip Code

Social Security #: _____ DL #: _____

Home #: _____ Cell #: _____

Email: _____

Employer: _____ Work #: _____

Parent's Marital Status ☐Married ☐Single ☐Divorced

☐Mother/Father ☐Step Mother/Father ☐Guardian

Name: _____ DOB _____
Address (if different than Child's):

_____
#Apt. /Condo

_____
City State Zip Code

Social Security #: _____ DL #: _____

Home #: _____ Cell #: _____

Email: _____

Employer: _____ Work #: _____

Child's Medical and Dental History

Why did you bring the child to see the dentist today?

_____

_____

Is the child currently in pain? ☐ Yes ☐ No

Does the child require antibiotics before dental treatment?

☐ Yes ☐ No

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

Is the child's water fluorinated? ☐ Yes ☐ No

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

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Does the child floss his/her teeth daily? ☐ Yes ☐ No

Please circle your water supply:

City Well Water Purified/Bottled

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

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

Are the child's immunizations current? ☐ Yes ☐ No

Please list any drugs that the child is currently taking:

_____

_____

Please list all allergies that the child has:

_____

Has the child experienced any of the following medical problems?

Y N	Abnormal Bleeding/ Hemophilia	Y N	Heart Murmur
Y N	ADD/ ADHD	Y N	Hepatitis
Y N	AIDS/HIV	Y N	High Blood Pressure
Y N	Anemia	Y N	Hives
Y N	Any Hospital Stays	Y N	Hearing Loss
Y N	Asthma	Y N	Heart Surgery
Y N	Autism	Y N	Kidney Problems
Y N	Bladder Problems	Y N	Leukemia
Y N	Blindness/ Low vision	Y N	Liver Problems
Y N	Bronchitis	Y N	Low Blood Pressure
Y N	Brain Injury	Y N	Lupus
Y N	Birth Defects	Y N	Measles
Y N	Cancer	Y N	Mental Retardation
Y N	Chicken Pox	Y N	Premature
Y N	Congenital Heart Defect	Y N	Psychological Prob.
Y N	Cerebral Palsy	Y N	Pneumonia
Y N	Diabetes	Y N	Rheumatic/Scarlett
Y N	Down Syndrome	Y N	Sickle Cell Disease
Y N	Epilepsy/Siezures	Y N	Spina Bifida
Y N	Fainting Spells	Y N	Tonsils Removed
		Y N	Tuberculosis

Please list any serious medical problems that child has experienced: _____

_____

_____

Does/did the child experience any of the following?

Y N	Breast Fed	Y N	Nursing Bottle Habits
Y N	Chewing on Objects	Y N	Speech Problems
Y N	Clench/Grind teeth	Y N	Thumb/Finger Sucking
Y N	Lip Sucking/Biting	Y N	Tongue/Cheek Sucking
Y N	Mouth Breather	Y N	Tongue Thrust
Y N	Chronic Earaches	Y N	Used Pacifer

Parent Acknowledgement

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____ _____

Signature of Parent/Guardian Date

Office Use Only Office Use Only Office Use Only

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein.

_____ _____

Signature of Dentist Date

Alternate Caregiver Information

I authorize the following individual(s) to bring my child to their appointments:

Name _____ DOB _____ Relationship to child _____

Name _____ DOB _____ Relationship to child _____

I attest that the above named individual(s) are all over 18 years of age as of this date. I authorize the individuals to consent to treatment for my child. This may include, but is not limited to, diagnostic, preventative, and restorative treatment. I understand that the doctor will communicate her findings and treatment plan to the caregiver who brings the child, and that under most circumstances a follow-up call to me personally should not be necessary. I attest that I am the parent or legal guardian of the child and that I have the legal authority to make this agreement.

_____ _____ _____

Parent/Guardian Signature **Date** **Relationship to patient**

Primary/Secondary Insurance Information

Primary Dental Insurance

Policy Owner's Name_____

Ins. Co Name _____

Address _____

_____

Ins. Co Number _____

Group # _____ ID # _____

Employer _____

Secondary Dental Insurance

Policy Owner's Name_____

Ins. Co Name _____

Address _____

_____

Ins. Co Number _____

Group # _____ ID # _____

Employer _____

Financial Policy/ Contract of Care

Please carefully review and sign our Financial Policy below. If you have any questions or concerns about our policies, please do not hesitate to speak to one of our team members.

1. Patients with dental insurance must provide accurate and complete insurance information. We will be happy to file for your insurance benefits and submit your claim as a courtesy to you. If insurance coverage cannot be covered, you will be responsible for payment of all fees.
2. Prior to completing any restorative treatment, we will provide you with a treatment plan, which includes our total fee, your estimated insurance coverage, and your estimated out of pocket costs.
*Please remember, these are only estimates and may change during the course of treatment. Sometimes, treatment alternatives become necessary for various reasons, which may increase or decrease treatment costs.
3. Any amount not covered by your insurance company is payable at the time services are rendered. These fees may include deductibles, co-payments or certain procedures not covered by your insurance policy. Most insurance does not tell us exactly what they will cover, so we are only giving you our best estimate of what you will have to pay.
    *For your convenience we accept cash, personal checks, and the following credit cards: Master Card, Visa, Discover, and American Express. Any returned checks will incur a $30.00 service charge.
4. Any remaining balance will be billed to you after a claim is paid. Payment is due upon receipt of your statement. If your account is not paid within 60 days, you will be liable for any collection fees or interest charges incurred while collecting your account.
5. We ask that you give at least 48 hours' notice if you need to cancel or change an appointment so we can make the time slot available for another patient. We realize that unexpected things may happen but ask for your assistance with this regard. In the event that you fail to keep your child's appointment without at least 48 hours' notice, we reserve the right to discontinue treatment for your child or children and report to your insurance company.

I have read and accept the above Financial Policy. I understand, acknowledge and agree that I am fully responsible for the total payment of all procedures performed including treatment that is not a benefit of any dental insurance that I may have.

_____ _____ _____

Parent/Guardian Signature **Date** **Relationship to patient**

Smile Reminder

In an effort to improve communication with our patients, It's A Small World will be E-mailing and/or texting appointment reminders. If you are interested in being a part of this service, please enter your information below. Please be aware that this email address may also be used to email you personal information (ie. Receipts, Invoices, Letters) relating to your dental care. Your information is only used for communication with you and other dental professionals. We do NOT share or sell personal information.

Personal E-mail: _____Mobile Phone #:_____

_____ _____ _____

Parent/Guardian Signature **Date** **Relationship to patient**

HIPPA

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices or to document our good faith effort to obtain that acknowledgement.

**** You May Refuse to Sign This Acknowledgement****

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

_____

{Please Print Name}

_____

{Signature}

_____

{Date}

Authorization to Release Information

_____ _____

{Please Print Name} **Relationship**

_____ _____

{Please Print Name} **Relationship**

_____ _____

{Please Print Name} **Relationship**

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ **Individual refused to sign**
- ☐ **Communications barriers prohibited obtaining the acknowledgement**
- ☐ **An emergency situation prevented us from obtaining acknowledgement**
- ☐ **Other (Please Specify)**