

Smile Starters

General Dentistry for Youth
first tooth through age 20

Health History

Patient's Name: First Last

Date of birth: Month Day Year

Dental History:

What brings you to the dental office today?

How long since the patient's last dental visit? 6 months more than 6 months more than a year never

Does the patient have any dental pain at this time? Yes No If yes, please explain

How often does the patient brush? once per day twice per day sometimes never

How often does the patient floss? once per day twice per day sometimes never

Does the patient have any of the following oral habits?

Suck their finger, thumb or pacifier Nail Biting Lip Sucking Biting Grinding

Is the patient breast feeding? Yes No or still on the bottle? Yes No

Has the patient experienced a history of trauma or falls involving the face or teeth? Yes No If yes, please

explain

Medical History:

	<u>Yes</u>	<u>No</u>
Is the patient under the care of a specialist now? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient ever been hospitalized or had a major operation? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Has the patient ever had a serious head or neck injury? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient on a special diet? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient use tobacco? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Does the patient use controlled substances? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is the patient pregnant or trying to get pregnant? If yes, how many weeks? <input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>
When was the patient's last checkup with their physician? <input type="checkbox"/> within a year <input type="checkbox"/> more than a year <input type="checkbox"/> never		
List all medications, pills or drugs currently taken <input type="text"/>		

Please mark the boxes below if the patient is allergic to any of the following:

Aspirin Penicillin Codeine Latex Metal Sulfa

Does the patient have any other allergies? Please list

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Health History (Continued)

Does the patient have or have they ever had any of the following?

	<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>		<u>Yes</u>	<u>No</u>
ADD/ADHD	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Mental health care	<input type="checkbox"/>	<input type="checkbox"/>
AIDS/HIV Positive	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Premature Birth	<input type="checkbox"/>	<input type="checkbox"/>
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Excessive thirst	<input type="checkbox"/>	<input type="checkbox"/>	Radiation Treatment	<input type="checkbox"/>	<input type="checkbox"/>
Artificial Heart Valve or Joint	<input type="checkbox"/>	<input type="checkbox"/>	Fainting Spells/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Growth Problems	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet Fever	<input type="checkbox"/>	<input type="checkbox"/>
Autism/Spectrum disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia or Trait	<input type="checkbox"/>	<input type="checkbox"/>
Birth Defects	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Failure	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	<input type="checkbox"/>
Blood Disease	<input type="checkbox"/>	<input type="checkbox"/>	Heart Trouble/Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Problems	<input type="checkbox"/>	<input type="checkbox"/>
Breathing Problem	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Bruise Easily	<input type="checkbox"/>	<input type="checkbox"/>	Hearing impaired	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid or other gland disorder	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis A, B or C	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Tumors or Growths	<input type="checkbox"/>	<input type="checkbox"/>
Cold Sores/Fever Blisters	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>
Congenital Heart Defect	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Rash	<input type="checkbox"/>	<input type="checkbox"/>	Vision impaired	<input type="checkbox"/>	<input type="checkbox"/>
Developmental delay	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Problems	<input type="checkbox"/>	<input type="checkbox"/>	Yellow Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Limitations in using arms or legs	<input type="checkbox"/>	<input type="checkbox"/>
Drug Addiction	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease/Problem	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>
Easily Winded	<input type="checkbox"/>	<input type="checkbox"/>	Low Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>			
Eating Disorder	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>			

Does the patient have any other medical condition not listed above?

Comments:

X _____

Signature of Parent/Legal Guardian

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Dear Parent/Guardian,

Thank you for bringing your child (children) into our dental office today. The privacy of your health information is important to us. Upon arrival, you should have been offered a copy of the Smile Starters "Notice of Privacy Practices". While we do not share your information to outside firms for marketing purposes, we will as a service to our patients, provide a courtesy appointment reminder call and possibly other important calls that may be placed using a prerecorded message.

By signing this document, you are acknowledging a copy of the Smile Starters "Notice of Privacy Practices" has been made available to you. A copy of our privacy practices can also be found at www.smilestartersdental.com. You are also consenting to receiving prerecorded messages to the phone numbers provided below for appointment reminder purposes or other important calls as may be required. To opt out, follow the message prompts.

Once again, we thank you for allowing Smile Starters to provide your dental services today.

Sincerely,

Your Smile Starters Team

Child Name: _____

Printed Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____ Date: _____

Home Phone Number: _____

Mobile Phone Number: _____

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Welcome to Smile Starters! Thank you for selecting our office for your child's dental care. We are committed to providing excellent dental care for our patients. The following information will acquaint you with our office financial policies.

- **Insurance Benefits:** We are happy to complete and submit your insurance forms on your behalf. Every effort will be made to collect the maximum benefits allowed by your insurance company. However, your insurance is a contract between you and your insurance company. We ask that you read your policy carefully. Some or all of the services we provide may not be a covered benefit. We will do our best to give you an accurate estimate, but we cannot guarantee the insurance payments in advance of submitting the claim. Any balances remaining after your insurance pays are due within 10 days of billing.
- **Payment:** Our policy is to collect FULL PAYMENT at the time of service. If insurance benefits apply, patient CO-PAYMENTS, DEDUCTIBLES AND CO-INSURANCE are due at the time of service unless other arrangements have been made. VISA, Mastercard, and Cash are accepted.
- **Services:** In order to properly diagnose and treat our patients, we require diagnostic aids such as radiographs and intra-oral photos. Please understand that when transferring to our office from another dental office, at times the radiographs we receive are not of diagnostic quality and may need to be retaken in order to treat you or your child. We will make every attempt to receive payment from your insurance company, but you will be billed for any necessary diagnostic aids taken but not paid for by your insurance company.

I have read and agree to the financial policies of Smile Starters:

X

Signature of Parent/Legal Guardian

Rafael Rivera Jr., DDS, PLLC

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**CONSENT FOR USE AND DISCLOSURE
OF HEALTH INFORMATION**

Please list the names of all the children you make health care decisions for at this clinic:

If you would like any other person to have access to your child's health information, or if someone other than yourself will be bringing the child to the clinic, please list their name and relationship to the child below:

I, _____ AUTHORIZE THE PERSONS NAMED ABOVE TO BRING MY CHILD TO THEIR DENTAL APPOINTMENTS AND TO MAKE ANY DENTAL TREATMENT AND EMERGENCY CARE DECISIONS NECESSARY.

Printed Name of Parent/Legal Guardian

X _____
Signature of Parent/Legal Guardian

Rafael Rivera Jr., DDS, PLLC