Smile Bright
Pediatric Dental Care

New Patient Information

TELL US ABOUT YOUR CHILD

Today's Date: _____ Child's Birthdate: ____/____/_____ Child's Age: _____ ☐ Male ☐ Female ☐ Non-Binary

Child's Name: _____ Nickname: _____
LAST FIRST MIDDLE

School: _____ Grade: _____ Home#: _____ SS#: _____

Address: _____
#APT/CONDO

_____
CITY STATE ZIP CODE

WHO IS WITH THE CHILD TODAY?

Name: _____ Relation: _____

Parental Marital Status: ☐ Single ☐ Married ☐ Divorced Is Your Child Adopted? ☐ Yes ☐ No

Do You Have Legal Custody Of This Child? ☐ Yes ☐ No If Yes, ☐ Full ☐ Shared

If I cannot make the appointment, I Consent To _____ Bringing In My Child For Future Appointments.

Do They Have Permission To Approve Dental Procedures? ☐ Yes ☐ No

Who May We Thank For Referring You? _____ Other Family Seen By Us? _____

Previous Dentist/Last Visit: _____

Address: _____

Phone#: _____ Last Visit: _____

MOTHER/LEGAL GUARDIAN INFORMATION:

Name: _____ ☐ Check If Deceased SS#: _____

Work#: _____ Ext. _____ HM# _____ DL#: _____

Employer: _____

FATHER/LEGAL GUARDIAN INFORMATION:

Name: _____ ☐ Check If Deceased SS#: _____

Work#: _____ Ext. _____ HM# _____ DL#: _____

Employer: _____

RESPONSIBLE PARTY INFO:

Name: _____ Cell#: _____ HM# _____

Billing Address: _____

_____
CITY STATE ZIP CODE

Employer: _____ Work#: _____ Ext. _____ DL#: _____

SS#: _____ Email: _____ **Do You Have Dental Insurance? ☐ Yes ☐ No**

PRIMARY DENTAL INSURANCE

Ins. Name: _____

Ins. Address: _____

_____
CITY STATE ZIP CODE

Insurance Co Phone#: _____ Group Policy#: _____ SS#: _____

Insured's Name: _____ Relationship To Patient: _____

Insured Date of Birth _____ Insured Employer: _____

SECONDARY DENTAL INSURANCE

Ins. Name: _____

Ins. Address: _____

_____
CITY STATE ZIP CODE

Insurance Co Phone#: _____ Group Policy#: _____ SS#: _____

Insured's Name: _____ Relationship To Patient: _____

Insured Date of Birth _____ Insured Employer: _____

DENTAL HISTORY

Why did you bring the child to see the dentist today? ☐ Referred ☐ Trauma ☐ Emergency ☐ Consultation

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 fluoride? ☐ Yes ☐ No Is the child taking fluoridated supplements? ☐ Yes ☐ No

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

Does the child help with oral hygiene? ☐ Yes ☐ No

Child's Physician: _____ Phone#: _____ Date of Last Visit: _____

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

Please describe the child's current physical health ☐ Good ☐ Fair ☐ Poor

Please list any drugs that the child is currently taking _____

Please list all drugs that the child is allergic to _____

Allergic To Latex ☐ Yes ☐ No Allergic to Nickel ☐ Yes ☐ No Allergic to Metals ☐ Yes ☐ No

Allergic to Plastic ☐ Yes ☐ No

Primary Language Spoken: ____ English ____ Spanish ____Vietnamese ____ Chinese ____ Arabic ____ Other (_____)

MEDICAL HISTORY

Has the child experienced any of the following medical problems or been diagnosed with any of the following:

- ☐ Abnormal Bleeding/Hemophilia/ Von Williebrand
- ☐ ADD/ADHD
- ☐ AIDS/HIV +
- ☐ Anemia
- ☐ Any Hospital Stays/Operations?
- ☐ Artificial Bones/Joints/Valves
- ☐ Asthma- Stable or Unstable?
- ☐ Autism Spectrums/SPD/ Asperger
- ☐ Cancer _____
- ☐ Chicken Pox
- ☐ Congenital Heart Defect
- ☐ Convulsions
- ☐ Diabetes - Type I/Type II
- ☐ Epilepsy
- ☐ Handicaps/Disabilities
- ☐ Hearing Impairment
- ☐ Heart Murmur: Any other heart disorders, concerns or issues
- ☐ Bronchitis/RAD
- ☐ Hepatitis - A, B, or C
- ☐ High Blood Pressure
- ☐ Hives
- ☐ Immune Suppressive Therapy
- ☐ Kawasaki Disease
- ☐ Kidney Problems
- ☐ Liver Problems
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Measles
- ☐ Mitral Valve Prolapse
- ☐ Mononucleosis
- ☐ Prosthetics
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Scarlet Fever
- ☐ Skin Rash
- ☐ Tuberculosis (TB)
- ☐ Sensory Integration Disorder/ Dysfunction

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

Is there anything you would like to discuss with the Doctor in Private? ☐ Yes ☐ No

Please discuss any serious medical problems the child experiences/ed: _____

_____

Does/did the chilld experience any of the following:

- ☐ Bottle for Feedings
- ☐ Breast Fed
- ☐ Chewing on Objects
- ☐ Clenching/Grinding Teeth
- ☐ Dental Phobia
- ☐ Lip Sucking/Biting
- ☐ Pacifier
- ☐ Mouth Breather
- ☐ Nail Biting
- ☐ Speech Problems
- ☐ Thumb/Finger Sucking
- ☐ Tongue/Cheek Sucking
- ☐ Tongue Thrust
- ☐ Full Term Birth
- ☐ Permature Birth _____ weeks

OUR OFFICE IS HIPAA COMPLIANT AND IS COMMITTED TO MEETING OR EXCEEDING THE STANDARDS OF INFECTION CONTROL MADE BY OSHA, THE CDC, AND THE ADA

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 stadd to perform the necessary dental services muy child may need.

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE

INSURANCE RELEASE

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____ _____

SIGNATURE OF PARENT OR GUARDIAN DATE

CONSENT FOR BASIC ROUTINE DENTAL CARE

I give consent to dentist to perform routine examination, cleanings, x-rays, and fluoride treatment.

_____ _____ _____

PRINT SIGNATURE RELATIONSHIP TO CHILD

OFFICE USE ONLY

I verbally reviewed the medical/dental information about the parent/guardian & patient named herein.

Initials: _____ Date _____

Doctor's Comments: _____ ASA, I, II, III, or V _____

WHICH OFFICE ARE YOU SEEN

☐ METAIRIE | 3330 Kingman Street, Suite 1 | Metairie, LA 70006

☐ HARVEY | 2744 Manhattan Blvd., Suite A | Harvey, LA 70058

Smile Bright
Pediatric Dental Care

Appointment Cancellation/No-Show policy

Thank you for trusting your dental care to Smile Bright Dental Care. When you schedule an appointment with Smile Bright Dental Care, we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment, please contact our office as soon as possible, and no later than 24 hours prior to your schedule appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No-Show Policy below:

- Effective 8/25/2021 — any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24-hour notice** will be considered a no show and charged a **$35 fee.**

- If a third no show or cancellation/reschedule without 24-hour notice should occur, patient may be **dismissed** from Smile Bright Dental Care.

- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your scheduled appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the no show fee.

I have read and understand the Appointment Cancellation/No-Show Policy and agree to its terms.

_____ _____

Signature (Parent/Legal Guardian) Relationship to Patient

_____ _____

Printed Name Date

Cell Phone Policy

By signing this, I acknowledge that I am aware of and understand Smile Bright Pediatric Dental Care's policy pertaining to cell phone usage in the office.

Further by signing this, I also acknowledge and understand that the cell phone policy prohibits taking pictures or recording video of my child or any other patient while they are receiving treatment.

I understand that failure to comply with the policy will result in immediate discontinuation of treatment and possible dismissal as a patient of Smile Bright Pediatric Dental Care.

_____

First & Last Name (Print)

_____

Signature

_____

Date

Smile Bright
Pediatric Dental Care

Cell phone usage includes taking pictures or recording video of your child or any other patient while they are receiving treatment. Failure to comply with this policy will result in immediate discontinuation of the current treatment that is being provided.