New Patient Information

TELL US ABOUT YOUR CHILD

Today's Date: _____

Child's Name: _____ ☐ Male ☐ Female ☐ Non-Binary
LAST MIDDLE FIRST

Child's DOB: _____ Child's Age: _____ Nickname: _____
MONTH/DAY/YEAR

Social Security #: _____ Child's Home #: _____

Child's Primary Home Address: _____
APT/CONDO

_____
CITY STATE ZIP CODE

How did you find out about us? ☐ Internet ☐ Social Media ☐ Insurance ☐ Friend ☐ Other: _____

Were You Referred? ☐ Yes ☐ No Referred By: ☐ Friend ☐ Dentist ☐ Other: _____

WHO IS WITH THE CHILD TODAY?

Name: _____ Relation: _____

Do You Have Legal Custody of This Child? ☐ Yes ☐ No If Yes, ☐ Full ☐ Shared Is Your Child Adopted? ☐ Yes ☐ No

Parental Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

If I cannot make the appointment, I consent to _____ to bring my child for future appointments.

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

Previous Dentist: _____ Date of Last Visit: _____

Other Family Seen By Us: _____

MOTHER/LEGAL GUARDIAN INFORMATION:

Name: _____ ☐ Check if Deceased ☐ Domicile Parent

Phone #: _____ Alternate: _____ Social Security #: _____

Driver's License #: _____

Address: _____

Employer: _____

FATHER/LEGAL GUARDIAN INFORMATION:

Name: _____ ☐ Check if Deceased ☐ Domicile Parent

Phone: _____ Alternate: _____ Social Security #: _____

Driver's License #: _____

Address: _____

Employer: _____

PRIMARY DENTAL INSURANCE

Do You Have Dental Insurance?: ☐ Yes ☐ No Out of Network? ☐ Yes ☐ No

Insurance Name: _____ Insurance Phone #: _____

Claim's Address: _____

_____
CITY STATE ZIP CODE

Member ID #: _____ Group/Policy #: _____ Social Security #: _____

Insured's Name: _____ Insured DOB: _____ Relationship to Patient: _____

Insured Employer: _____

SECONDARY DENTAL INSURANCE

We do not file secondary insurance. Only federal and Medicaid plans.

Do You Have Dental Insurance?: ☐ Yes ☐ No

Insurance Name: _____ Insurance Phone #: _____

Claim's Address: _____

_____
CITY STATE ZIP CODE

Member ID #: _____ Group/Policy #: _____ Social Security #: _____

Insured's Name: _____ Insured DOB: _____ Relationship to Patient: _____

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 Allergic to Medicine ☐ Yes ☐ No If yes, _____
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/ODD
- ☐ 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
- ☐ Depression
- ☐ Diabetes - Type I/Type II
- ☐ Down Syndrome
- ☐ 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 my 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

Parent/Legal Guardian Agreement

Please review the following policies carefully. By signing below, you acknowledge that you understand and agree to these terms.

1. Appointment Cancellation/No Show Policy:

When you schedule an appointment, our staff reserves dedicated time to provide your child with the highest quality care. Please notify us at least 24 hours in advance if you need to cancel or reschedule. We allow a 10-minute grace period for late arrivals; after 10 minutes without notice, the appointment will be considered a "fail." Repeated failed appointments may result in dismissal from the practice.

- Any established patient who fails to show or cancels/reschedules an appointment without at least 24 hours' notice will be considered a No Show and charged a $35 fee.
- If a third No Show or cancellation/reschedule with no 24-hour notice occurs, the patient may be dismissed from Smile Bright Pediatric Dentistry.
- As a courtesy, when time allows, we make reminder calls or messages. If you do not receive one, the above policy will still apply.
- We understand emergencies may occur. If you experience extenuating circumstances, please contact our Office Manager, who may be able to waive the No Show fee.

***Appointment Confirmation Policy for Dental Restorations:**

To ensure we can provide the best possible care and keep our schedule running smoothly, we require confirmation for all dental appointments by 12:00 PM the day before the scheduled appointment. If we do not receive confirmation by the specified time, the appointment will be cancelled.

2. Fees/Payments:

We accept cash, Visa, Mastercard, and Discover. Declined payments are subject to a $35 fee.

3. Insurance Policy:

As a courtesy, we will verify your insurance and file claims for you. It is your responsibility to notify our office of any insurance changes. Since insurance policies vary, we can only estimate your coverage, but payment of your estimated portion is required at the time of service. Insurance is not a guarantee of payment.

4. Collections Accounts:

Accounts over 90 days past due will be referred to a collection agency. You are responsible for any and all costs involved with the collections process.

5. Office Visit Policy:

You are welcome to stay with your child during hygiene visits. If treatment is required, only one parent or guardian may accompany the child in the treatment room. For safety and to ensure a positive experience, please refrain from bringing other children or patients into the treatment room. All patients must be accompanied by a legal guardian.

6. Cell Phone Policy:

Smile Bright Pediatric Dentistry does not allow cell phone usage in the office during treatment. This includes taking photos or recording videos of your child or any other patients while they are receiving treatment. Failure to comply with this policy may result in immediate discontinuation of treatment and possible dismissal as a patient.

I have read and understand the Smile Bright Pediatric Dentistry Parent Agreement and agree to its terms.

Printed Name: _____ Signature: _____

Date: _____

Smile Bright
Pediatric Dental Care
Dr. Linda Cao

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

X Name: _____

X Address: _____

X Telephone: _____ E-mail: _____

Patient #: _____ Social Security #: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. IF we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Person: Gina Decastro

Telephone: 504-207-0314 Fax: 504-609-3727

E-mail: _____

Address: 2744 MANHATTAN BLVD. SUITE A, HARVEY, LA 70058

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SIGNATURE

X I, _____, have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

X Signature: _____ X Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will not affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____