Smile Reef

Date: **Patient Registration** **Please Print**

Patient Name_____ Nickname _____ DOB_____Sex_____

Patient's Address_____

Street Name Apt/Unit# City State Zip

Fathers' Name _____DOB_____Mother's Name_____DOB_____

Parent's Marital Status _____ Address (if different from above) _____

Father's Employer_____SSN_____Mobile Phone#_____

Mother's Employer_____SSN_____Mobile Phone#_____

Primary Insurance

Subscriber's Name _____DOB_____SSN_____

Insurance Name_____Subscriber's Employer_____

Subscriber's ID # _____Group #_____

Secondary Insurance

Subscriber's Name _____DOB_____SSN_____

Insurance Name_____Subscriber's Employer_____

Subscriber's ID # _____Group #_____

Smile Reef can E-Mail you any personal information that is consented to (ie. Receipts, Invoices, Treatment Plans, Letters, etc.) relating to your child's dental care. Your information is only used for communications with you and other dental professionals. We do NOT share or sell any personal information.

Personal E-Mail _____Phone #_____

(Please Print Clearly) (text & confirming appointments)

INFORMED CONSENTS FOR PARENTS/GUARDIANS ACCOMPANYING THE CHILD

I hereby authorize the dentist and staff at Smile Reef to perform diagnostic aids including an examination, x-rays, photographs, models, cleanings and fluoride/varnish treatments, when necessary, as the standard of care to properly diagnose and record any and all dental conditions. I authorize my insurance company to pay Smile Reef all insurance benefits otherwise payable to me for services rendered. I also authorize the use of this signature on all insurance submissions. I understand that I am financially responsible for all changes for services rendered whether or not it is covered by my insurance, all broken appointment fees and all late payment service charges. I also understand that obtaining insurance coverage and benefits information is my responsibility and not the responsibility of Smile Reef. This consent is to remain in effect from the date indicated until cancelled in writing.

Authorized Signature_____

Relationship to Child **Date**

Board Certified
Pediatric Dentistry

HEALTH HISTORY

Date: _____

PERSONAL

Child's Name_____Age_____DOB_____
Nickname(if any) _____Sex_____Place of Birth_____
What is your child most interested in? _____
Child's Pediatrician/Phsician_____Phone#_____
Family Dentist_____Phone#_____

MEDICAL

PLEASE CIRCLE EACH ONE INDIVIDUALLY

Has your child had or have any of the following medical problems?

Allergies to food	Y N	Down Syndrome	Y N	Hospital stay/Operation	Y N
Allergies to drugs	Y N	Handicap/Disability	Y N	Learning disabilities	Y N
Allergies to latex	Y N	Heart Defect (congenital)	Y N	Trauma to mouth/face	Y N
Asthma or lung problems	Y N	Heart Murmur	Y N	Tuberculosis (TB)	Y N
Blood transfusions	Y N	Hemophilia or abnormal bleeding	Y N	Autism	Y N
Cancer	Y N	Hepatitis	Y N	ADD/ADHD	Y N
Convulsion or epilepsy	Y N	High Fevers	Y N	Cerebral Palsy	Y N
Diabetes	Y N	HIV+/AIDS	Y N	Developmental delay	Y N

Other medical problems:_____
Is the child in good health?_____
Has your child ever been hospitalized (overnight) if so, when and why?
_____
_____
Has your child had any unfavorable reactions to drugs, antibiotics or anesthetics? Y N What kind?_____
Is your child currently taking any medications? Y N What kind?_____
Is your child taking any supplemental fluoride? Y N If yes, how? Tablets, Drops, Water, Vitamins (please circle)
Does your child have any breathing problems? Y N Breaths primarily through; Nose or Mouth (please circle)
Does your child snore? Y N

HABITS

Has your child had or have any of the following habits?

Thumb or finger sucking	Y N	Does your child currently nurse?	Y N
Lip sucking or biting	Y N	Does your child currently use a bottle?	Y N
Biting hard objects	Y N	Did your child use a bottle?	Y N
Nail biting	Y N	Is the bottle used at night?	Y N
Tooth grinding	Y N	Pacifier use?	Y N

CHILD'S DENTAL HISTORY

Has your child seen a dentist before? Y N
If yes, approximate month/year of last visit: _____ Where?_____
Has your child had any unfavorable experiences Y N
Does your child have any dental problems presently Y N
If yes, please explain: _____
Do you help your child brush his/her teeth Y N How many times day _____
Do you help your child floss Y N How many times day _____
How do you think your child will act towards the dentist _____
Purpose of today's dental visit _____

Guardian's Initials _____ Date _____ Examining Doctor's Initials _____ Date _____

Guardian's Initials _____ Date _____ Examining Doctor's Initials _____ Date _____

EXAM CONSENT

EXAM CONSENT

I understand that by signing below that I request and authorize the procedure to be done and have read and understand the possible risk and complications of the procedure.

X-RAYS & EXMAINIATION

I understand that my child will be receiving a dental examination from a state licensed dental practitioner, I understand that while x-rays are taken on my child's teeth he/she will be exposed to minimal amount of radiation as part of the necessary requirements to complete a thorough and comprehensive examination. I also understand that if I am pregnant, radiation exposure possess a serious threat to the life and health of my unborn child. Pregnant women are required to have a medical release from their medical doctor prior to x-rays and dental treatment.

CHANGES IN TREATMENT

I understand that during treatment, it may be necessary to change procedures or add procedures because of conditions discovered while working on teeth that were not found during examination. I understand that there may be unforeseen changes that may occur during treatment. I understand that whenever possible, I will be informed of any treatment changes in advance. I give my permission to the Dentist to may any/or all changes and additions as necessary.

MEDICATIONS

I understand that antibiotics, analgesics, and other medications can cause allergic reactions; Smile Reef and the treating dentist are not responsible for any allergic reactions that take place during this procedure.

HIPPA ACKNOWLEDGEMENT

Patient Acknowledgement of Receipt of Notice of Privacy Practices

The Health Insurance Portability and Accountability Act (HIPPA) requires that effective April 14, 2003, patients be given a copy of our Notice of Privacy Practices.

If you would please print your name below.

I, _____ acknowledge that I have received from this office a copy of the office Notice of Privacy Practices.

_____

(Authorized Signature) **(Relationship to Child)** **(Date)**

Thank you, for taking the time to read and sign these documents.