



Patient Information

Patient Name: _____ Date: _____

Gender: Male Female Mother's name: _____ Father's Name: _____

Birth Date: _____

Address: _____
Street Apartment #
City State Zip Code

Referral Information

Whom may we thank for referring you to our practice? Another patient, friend Another patient, relative
 Dental Office Google Newspaper School Work Other _____

Name of person or office referring you to our practice: _____

Responsible Party Information

the person responsible for payment

Guarantor Name: _____
Last, First MI (Preferred Name)

Gender: Male Female Family Status: Single Married Divorced Widowed

Birth Date: _____ Driver's License #: _____

Phone (Home): _____ (Work): _____ Ext: _____ Mobile: _____

Home Address: _____
Street Apartment #
City State Zip Code

Employer Name: _____ Occupation: _____

Address: _____
Street City, State Zip Code

Insurance Information

Primary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ SS#: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Secondary

Name of Insured: _____ Is insured a patient? Yes No

Insured's Birth Date: _____ ID #: _____ Group #: _____

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

Address: _____
Street City State Zip Code

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

Health Information

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental condition, but they are associated with proper oral health care.

Please answer each question. Check the appropriate box and/or circle **Yes** or **No** where applicable.

Date of Last Dental Visit: _____ Reason for this visit: _____

Have you ever had any of the following? Please check those that apply:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Sinus Problems |
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Ear Infections | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stomach Problems |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Excessive Bleeding | <input type="checkbox"/> Mental Disorders | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Artificial Joints | <input type="checkbox"/> Fainting | <input type="checkbox"/> Measles | <input type="checkbox"/> Tumors |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Bladder Problems | <input type="checkbox"/> Growths | <input type="checkbox"/> Nervous Disorders | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Codeine Allergy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Head Injuries | <input type="checkbox"/> Prematurity | <input type="checkbox"/> Penicillin Allergy |
| <input type="checkbox"/> Cerebral Palsy | <input type="checkbox"/> Hearing Problems | <input type="checkbox"/> Psychiatric Treatment | OTHER: |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Radiation Treatment | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Respiratory Problems | <input type="checkbox"/> _____ |
| | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Rheumatic Fever | |
| | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatism | |

1. Is your child in good health? Yes No
2. Date of last physical exam? _____
3. Is your child currently under the care of a physician? Yes No _____ If so, what is the condition being treated?

4. Has your child ever had any serious illness or operation? Yes No _____ If so, what is the illness or operation?

5. Has your child ever been hospitalized? Yes No _____ If so, what for? _____
6. Has your child ever been pre-medicated with antibiotics for your dental treatment? Yes No _____ If so, with what antibiotic and what dosage? _____
7. Please list all medications your child is currently taking: _____
8. **Are you sensitive to or allergic to any drugs or materials? Please circle any that apply.**

<input type="checkbox"/> Penicillin	<input type="checkbox"/> Codeine
<input type="checkbox"/> Tetracycline	<input type="checkbox"/> Latex
<input type="checkbox"/> Sulfa Drugs	<input type="checkbox"/> Other, Please list _____
<input type="checkbox"/> Aspirin	

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date: _____

Signature of patient, parent or guardian

Consent for Treatment: I hereby grant authority to the dentist(s) in charge of the care of the patient whose name appears on this Health History form, to administer such anesthetics, analgesics, sedatives, nitrous oxide sedation and intravenous sedation; and to perform such operations as may be deemed necessary or advisable in the diagnosis and treatment of this patient. I have been informed of all possible complications of the procedures, anesthetics and/or drugs.

All services are rendered and accepted under the terms and conditions printed on the health history information form hereof:

Signed _____ Date _____ Relationship to patient _____

Dental History

These questions are for your benefit and assure that the treatment will take into consideration your past and present dental status. Some questions may seem unrelated to your condition, but they are associated with proper oral health

Please answer each question. Check the appropriate box and/or circle **Yes** or **No** where applicable.

Is this your child's 1st visit to the dentist? Yes No

1. Has your child had any trouble associated with previous dental treatment? Yes No
2. Has your child been cooperative with physicians and/ or dentists in the past? Yes No
3. Have you been satisfied with your previous dental care? Yes No
4. Does your child brush regularly? Yes No How long? 30 sec. 1 min. 2 min.
5. Does your child floss? Yes No
6. Do the gums bleed when brushing and flossing? Yes No
7. Does your child take fluoride in any form (IE. Drinking water, toothpaste, fluoride from a previous dentist, fluoride supplements)? Yes No
8. Does your child have any sensitivity to hot/cold or sweet/sour? Yes No
9. Does your child have any **pain** in his/her mouth? Yes No
10. Does your child gag excessively? Yes No
11. Does your child snore? Yes No
12. Has your child ever had any orthodontics? Yes No
13. Has your child ever complained of jaw joint pain or problems? Yes No
14. Does your child have any mouth habits? Yes No
 - a. If so, please circle any that apply:
 - i. Teeth grinding
 - ii. Thumb sucking
 - iii. Finger sucking
 - iv. Nail biting
 - v. Cheek and/or lip biting,
 - vi. Mouth breathing
 - vii. Nursing bottle habits
 - viii. Pacifier
15. Any injury to any teeth, mouth, head, or jaws by fall, blow, bump or otherwise? Yes No
16. Any unusual speech habits? Yes No
17. Any lost or missing teeth? Yes No
18. Does anyone in the family have an unusual dental history, such as missing or extra teeth? Yes No
19. Do you desire complete dental services for your child? Yes No
20. Do you desire cosmetic dental restorations for your child? Yes No
21. Do you desire sedation for your child during your child's dental treatment? Yes No

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Date: _____

Signature of patient, parent or guardian

Terms and Conditions

As a condition of treatment by Little Smiles of Orange County, I understand financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility on the part of each patient must be determined before treatment.

All dental services including emergency services, furnished to me are charged directly to me and I am personally responsible for payment of all dental services. If I carry insurance, I understand that Little Smiles of Orange County will help prepare my insurance forms to assist in making collections from my insurance companies and will credit such collections to my account. However, Little Smiles of Orange County cannot render services on the assumption that charges will be paid by an insurance company.

Assignment of Insurance: I hereby authorize all dental insurance payments to be paid directly to Little Smiles of Orange County.

I understand that I may incur a 1 ½% finance charge (18% APR) if my balance is carried beyond 60 days.

I understand the usual, customary and reasonable (UCR) fees quoted can only be extended for a period of 3 months from the date of the patient's exam.

I give permission for my dentist and his/her clinical team to take any necessary diagnostic films, photos, or study models to properly enable complete diagnosis and treatment. I am aware there may be additional charges for these procedures.

In consideration of the professional services rendered to me, or at my request, by the Doctor and/or staff, I agree to pay, thereof, the reasonable value of said services to said doctor, or his assignee, at this time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be billed unless abjected by me, in writing, within the time of payment thereof. Additionally, I agree that a waiver for any breach of any term or condition hereunder shall not constitute a waiver of any further term or condition. I further agree, in the event of any legal action, by either party, to enforce the collection of fees for Little Smiles of Orange County due under this agreement, the prevailing party shall recover reasonable attorney's fees and costs. In the event of any costs incurred in the collection of fees (such as agency fees) due under this agreement, the additional cost will be added to the account.

I grant my permission to you, or your assigns, to contact me by email, at home, on my mobile phone, or at my work to discuss matters related to this form.

Thank you for understanding the Financial Terms and Conditions of, Little Smiles of Orange County. Please let us know if you have any questions or concerns.

I have read the Financial Terms and Conditions. I understand and agree to Little Smiles of Orange County's Financial Terms and Conditions.

Signature/Guardian: _____ Date: _____