Topsfield SMILES

CHILD'S REGISTRATION AND HISTORY (CONFIDENTIAL)

Child's Name_____ Nickname_____

Sex: M ___ F ___ Birthdate_____ Age_____School_____Grade_____

Favorites interests, pets, sports, etc._____

Person to contact in case of emergency_____Phone_____

Whom may we thank for referring you to our office?_____

PARENT OR LEGAL GUARDIAN INFORMATION

Name _____ Birthdate_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email_____Soc. Sec. #: _____

Employer:_____Occupation:_____

OTHER PARENT OR LEGAL GUARDIAN INFORMATION

Name _____ Birthdate_____

Address_____ City_____ State_____ Zip_____

Home Phone_____ Work Phone_____ Cell Phone_____

Email_____Soc. Sec. #: _____

Employer:_____Occupation:_____

Child lives with: ❑Both Parents ❑Mom ❑Dad ❑Other

I understand and agree that I am responsible for all charges incurred.

_____

Signature of parent or legal guardian Date

PATIENT DENTAL HISTORY NAME:

Is this your child's first dental visit? ❑Yes ❑No If no, name of former dentist_____

Is this an emergency visit? ❑Yes ❑No Date of last visit_____

Have X-rays been taken? ❑Yes ❑No Date_____

Present dental problems or concerns (if any)_____

Has your child had any bad past dental experiences? ❑Yes ❑No
If yes, please explain:_____

Does your child brush daily? ❑Yes ❑No Does your child floss daily? ❑Yes ❑No

Does an adult assist with daily brushing and flossing? ❑Yes ❑No

Does your child receive fluoride in any of the following forms?

❑Vitamins ❑Water Supply ❑Tablets/Drops ❑Toothpaste ❑Rinse/Gel

Does your child have any of these habits?

❑Thumb/Finger Sucking ❑Pacifier ❑Mouth Breathing ❑Teeth Grinding ❑Nail Biting
❑Drink juice, milk, etc. near bedtime?

Does your child report any pain during chewing or while opening mouth wide? ❑Yes ❑No

Is there a history of trauma to the jaw, neck, or mouth region? ❑Yes ❑No
If yes, please explain:_____

Please check any of the following that may describe your child:

❑Outgoing ❑Shy ❑Stubborn ❑Anxious ❑Cautious ❑Frightened ❑Defiant
❑Curious ❑Moody ❑High Strung ❑Friendly ❑Cooperative ❑Other _____

PATIENT MEDICAL HISTORY

Child's Pediatrician_____Address_____Phone_____

Date of last physical_____ Are your child's immunizations up to date? ❑Yes ❑No

Is your child under medical care at present? ❑Yes ❑No
If yes, for what reason?_____

Is your child taking any medications or drugs? ❑Yes ❑No
If yes, please explain_____

Has your child ever been hospitalized or had surgery? ❑Yes ❑No
If yes, please explain_____

Does your child have allergies to any medications? ? ❑Yes ❑No
If yes, please explain_____

Does your child have any allergies to the following?

❑Aspirin ❑Erythromycin ❑Penicillin ❑Codeine
❑Sulfa ❑Latex ❑Local Anesthetic ❑Nitrous Oxide
❑Other (please list): _____

PATIENT MEDICAL HISTORY NAME: _____

Has your child ever been diagnosed as having any of the following conditions? (check all that apply)

❑ADHD
❑Aids
❑Allergies (Seasonal)
❑Anemia
❑Anxiety/Depression
❑Arthritis
❑Artificial Heart Valve
❑Artificial Joints
❑Asthma
❑Bleeding Disorders
❑Blood Disorder
❑Bruise Easily
❑Cancer
❑Chemotherapy
❑Chronic Adenoid/Tonsil Infection
❑Chronic Headaches
❑Chronic Ear Infections
❑Covid -19
❑Diabetes
❑Dizziness/Fainting
❑Drug Addiction
❑Emphysema
❑Epilepsy
❑Excessive Bleeding
❑Excessive Gagging
❑Glaucoma
❑Hay Fever
❑Heart Condition
❑Heart Murmur
❑Hepatitis (Types: A,B,C)
❑Herpes
❑High Blood Pressure
❑Hives/Rash
❑HIV Positive
❑Jaundice
❑Kidney Disease
❑Leukemia
❑Liver Disease
❑Mitral Valve Prolapse
❑Oral Ulcer
❑Pacemaker
❑Radiation (head/neck)
❑Respiratory Problems
❑Rheumatic Fever
❑Rheumatism
❑Scarlet Fever
❑Seizure Disorders
❑Sinus Problems
❑Sleep Apnea
❑Stomach Problems
❑Stroke
❑Thyroid Disease
❑Tuberculosis
❑Ulcer

❑ Other Medical or Dental information we should know about?

I understand the above dental and medical history was completed correctly to the best of my knowledge. I understand it is my responsibility to inform this office of any changes to the information I have provided.

_____

Signature of parent or legal guardian Date

PRIMARY DENTAL INSURANCE INFORMATION NAME: _____

Name of Insured_____ Relationship to Patient_____

Birthdate_____ Social Security #_____ Subscriber/Policy #_____

Name of Employer_____ Work Phone_____

Insurance Company Name_____ Group # _____

Ins. Co. Address_____ City_____ State_____ Zip Code_____

Insurance Company Phone #_____

How much is your deductible?_____ Maximum Annual Benefit_____

SECONDARY DENTAL INSURANCE INFORMATION_____

Name of Insured_____ Relationship to Patient_____

Birthdate_____ Social Security #_____ Subscriber/Policy #_____

Name of Employer_____ Work Phone_____

Insurance Company Name_____ Group # _____

Ins. Co. Address_____ City_____ State_____ Zip Code_____

Insurance Company Phone #_____

How much is your deductible?_____ Maximum Annual Benefit_____

PLEASE PROVIDE TO US YOUR DENTAL INSURANCE CARD SO THAT WE MAY MAKE A COPY FOR OUR RECORDS.

AUTHORIZATION AND RELEASE_____

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, mutual understanding between provider and patient.

Our policy requires payment in full for all services rendered at the time of visit, unless other arrangements have been made. If your account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

I authorize the provider to release any information required to properly diagnose, refer and process insurance claims.

I understand the above information, and guarantee this form was completed correctly to the best of my knowledge and understand it is my responsibility to inform this office of any changes to the information I have provided.

_____

Signature of patient (or parent/guardian if minor) Date

Topsfield SMILES

CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

You May Refuse to Sign This Acknowledgement

Date: _____

Print Patient Name: _____

I hereby give my permission to discuss all aspects of my dental treatment to the individuals listed below:

_____ Mother _____ Wife

_____ Father _____ Husband

_____ Other (Please specify) _____

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.

Patient/Legal Guardian Signature: _____

****

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communication barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (please specify)

_____

_____

_____
Employee Signature

YOU MAY OBTAIN A COPY OF OUR NOTICE OF PRIVACY PRACTICES ON OUR WEBSITE
WWW.TOPSFIELDSMILES.COM