Patient Information

Patient Name: _____ Date: _____
Last, First MI (Preferred Name)

Gender M/F Birth Date: _____ Weight: _____ How did you hear about our office?_____

Phone (Home): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

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

Has your child ever had any of the following? Please check those that apply:

- ☐ AIDS
- ☐ Allergies: Latex/foods/medication: _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Asthma
- ☐ ADHD
- ☐ Autism
- ☐ Bleeding Gums
- ☐ Bad Breath
- ☐ Behavior Concerns
- ☐ Birth Defects
- ☐ Bladder Problems
- ☐ Cerebral Palsy
- ☐ Chicken Pox
- ☐ Excessive Bleeding after bruising/extractions
- ☐ Fainting
- ☐ Ear Infections
- ☐ Epilepsy
- ☐ Hay Fever
- ☐ Head Injuries
- ☐ Heart Problems
- ☐ Heart Murmur
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Hearing Problems
- ☐ High Fevers
- ☐ Jaundice
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Mental Disorders
- ☐ Measles
- ☐ Mumps
- ☐ Mononucleosis
- ☐ Nutritional Problems
- ☐ Nervous Disorders
- ☐ Rheumatic Fever
- ☐ Rheumatic Heart
- ☐ Radiation Treatment
- ☐ Seizures
- ☐ Sinus Problems
- ☐ Sickle Cell
- ☐ Speech Problems
- ☐ Tuberculosis
- ☐ Tumors
- ☐ Thyroid Disease
- ☐ Tonsillitis
- ☐ Vision Problems
- ☐ Blood Transfusion Date: _____
- ☐Other____ _____

- Does the patient have any oral habits such as thumb sucking or sleeping with a bed-time bottle? ☐ Yes ☐ No
- What is the chief concern regarding the patient's oral health? _____
- Is the child presently in good health? ☐ Yes ☐ No
- Is the child taking any medications at this time? ☐ Yes ☐ No_____

- Were there any problems with the child during pregnancy, delivery or during the child's first year of life? ☐ Yes ☐ No
  If yes, please explain:_____
- Was the child considered a "preemie"? ☐ Yes ☐ No
- Is guardian: ☐ foster ☐ adopted ☐ biological ☐ other _____
- Has your child ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain: _____

- Has your child been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain: _____

- Is your child now under the care of a physician, including primary care? ☐ Yes ☐ No
  If yes, please explain: _____

- Was your child hospitalized in the first year of life? Please explain_____

- Name of Physician: _____ Phone: _____

- Does your child have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain: _____

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

Responsible Party Information

Name_____

☐ Male ☐ Female ☐ Married ☐ Single ☐ Other/Legal Guardian_____

Social Security #: _____ Birth Date: _____ DL#_____

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

Address: _____
Street Apartment #

_____
City State Zip Code

Insurance Information

Primary

Name of Insured: _____ SS#_____
Last First MI

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

Insured's Address: _____
Street City State Zip Code

Insured's Employer Name: _____

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

Insurance Plan Name and Address: _____

_____

Insurance Phone #_____

Acknowledgement of Receipt of Notice Of Privacy Practices

Purpose: This form is used to obtain acknowledgement of receipt of our Notice of Privacy Practices document, our good faith effort to obtain that acknowledgement.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACE PRACTICES

-I have received a copy of this office's Notice of Privacy Practices

-I have received a copy of this office's Notice of Privacy Practices, but I elect not to sign.

Please Print Name:_____

Please Sign Name:_____

Date:_____

* You May Refuse To Sign This Acknowledgement *

For Office Use Only

-We attempted to obtain oral-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
-Other, Please Specify_____

GrowingGrins
pediatric dentistry
3336 E. Chandler Heights Rd, Ste.130 | Gilbert, AZ 85297 | 480.813.3636

Consent for Pediatric Dental Treatment Of

_____
(Children's Names)

It is necessary for us as health professionals to obtain your consent for your child's planned dental treatment. Please read this form carefully we encourage you to ask questions about anything you do not understand.

1. I hereby authorize **Dr. Larry Jackson** and her assistants to perform upon my child the following dental treatment.
2. In general terms the dental procedures may include:

   A. Clinical Examination
   B. Tooth cleaning
   C. All necessary dental -rays
   D. Fluoride treatment

   We do not allow insurance to dictate what is recommended for your child; therefore Dr. Jackson recommends fluoride treatment two times per year and x-rays one time per year only if last check-up was cavity free and no suspicious areas on the clinical evaluation is revealed.

   * We are a preventive-focused practice and therefore strongly recommend applying sealants to grooves of teeth **(Guaranteed for one year from placement)**.

I have read and understand this form in its entirety.

_____ _____
Signature of Parent or Guardian Date

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Financial Agreement
We expect and appreciate your full payment for all charges at the time of your visit, unless prior arrangements have been made in advance. In the event that we are seeing your child on an emergency basis and prior financial arrangements cannot be made and\or insurance eligibility can not be verified all services must be paid for in cash at the time of services.

Insurance Filing
We file all primary dental insurance claims as a courtesy for our patients. We can only make an estimate regarding your insurance benefits based upon the information provided by you and by your insurance company, thus the patient is ultimately responsible for all fees not covered by the insurance company.

Assignment of Insurance Benefits
As our office files your insurance claims, please understand the following: I/We will hereby assign directly to Growing Grins PLLC., dental insurance benefits otherwise payable to me/us for dental treatment received and\or agreed upon this date. I\We hereby authorize the release of any\all information relating to my\our insurance claims I\We understand fully that we are responsible for all charges not paid by this assignment.

Delinquent Accounts
An account is considered delinquent when payment is delayed by 30 days or more. These accounts are subject to a reasonable service charge and\or legal interest rates.

Collection Proceedings
In the event that your account becomes delinquent for non-payment or insufficient funds you will be responsible for payment of reasonable collection costs\service charges of 30% and\or attorney fees, in addition to the balance owed. Accounts turned over to collections will forfeit any past special fees and\or discounts. Such special fees and\or discounts will be reversed and you will be responsible for the full fees for procedures at the initial time of service.

Failed Appointments
We understand that regrettable circumstances often prevent making a scheduled appointment, thus we will do our best to accommodate and reschedule your appointments. Additionally, we appreciate your understanding and adherence to notifying our office **not less that 24hrs** prior to your scheduled appointment. Because missed appointments are very costly to our practice any patients failing to show for an appointment will be assessed a $25.00 missed appointment fee, per child that is appointed.

Agreement
I\We have completely read and understand the content of this agreement and will comply with the policies within.

_____ _____
Responsible Party Signature Date