ALABASTER SMILES
PEDIATRIC DENTISTRY

Patient Personal Information

Patient Name: _____

Nickname: _____ ☐ Male ☐ Female

DOB: ___ / ___ / ___ Age: _____ SSN: ___ - ___ - _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

School name: _____

How did you hear about us? _____

Emergency contact: _____

Relation to patient: _____

Emergency contact phone: _____

Siblings that are also patients: _____

Insurance Information

Group ID: _____ Phone #: _____-_____-_____

Insurance Company: _____

Employer Name: _____

Subscriber Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Relationship to patient: _____

Subscriber ID: _____ DOB: _____/_____/_____

Parent/Legal Guardian

☐ Responsible Party

Name: _____

Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone: __ - __ - ___ Work Phone: __ - __ - ___

Cell Phone: __ - __ - ___ Driver's License #: _____

DOB: ___ / ___ / ___ SSN: ___ - _____ - _____

Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Parent/Legal Guardian

☐ Responsible Party

Name: _____

Relationship to patient: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Home Phone: __ - __ - ___ Work Phone: __ - __ - ___

Cell Phone: __ - __ - ___ Driver's License #: _____

DOB: ___ / ___ / ___ SSN: ___ - _____ - _____

Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced

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Medical History

Is the patient:

Currently under the care of a physician? ☐ Y ☐ N
If yes, what is the condition being treated? _____

_____

Physician Name: _____
Physician's Phone #: _____
Up to date with immunizations? ☐ Y ☐ N
Currently taking any medications? ☐ Y ☐ N
If yes, please list:

_____

_____

Preferred Pharmacy? _____

Has the patient:

Had any serious illness, operation, or been hospitalized in the last five years? ☐ Y ☐ N
If yes, explain: _____

_____

Ever had a serious head or neck injury? ☐ Y ☐ N
If yes, explain: _____

_____

Ever complained of TMJ discomfort? ☐ Y ☐ N

Allergies

- ☐ Aspirin
- ☐ Codeine
- ☐ Dental Anesthetic
- ☐ Erythromycin
- ☐ Iodine
- ☐ Latex
- ☐ Metals
- ☐ Nitrous Inhalation
- ☐ Penicillin
- ☐ Plastics
- ☐ Red Dye
- ☐ Sulfa Drugs
- ☐ Tetracycline
- ☐ Food Allergies:

_____

_____

- ☐ Other Allergies:

_____

_____

Medical History

- ☐ ADD/ADHD
- ☐ AIDS or HIV Infection
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis
- ☐ Artificial Joints
- ☐ Artificial Valves
- ☐ Asthma
- ☐ Autism/Sensory Disorder
- ☐ Behavioral Challenges
- ☐ Cancer
- ☐ Celiac Disease
- ☐ Cleft Lip/Palate
- ☐ Congenital Heart Defect
- ☐ Craniofacial Anomalies
- ☐ Diabetes - Type 1 or Type 2
- ☐ Depression/Anxiety
- ☐ Drug/Alcohol Abuse
- ☐ Eating Disorder
- ☐ Emphysema or COPD
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fever Blisters
- ☐ Frequent Cough
- ☐ Frequent Headaches
- ☐ Gene Mutation
- ☐ Hearing Impairment
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ Heart Surgery
- ☐ Hemophilia
- ☐ Hepatitis
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Kidney Problems
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Mitral Valve Prolapse
- ☐ Pacemaker
- ☐ Pain in Jaw Joints
- ☐ Physical Disability
- ☐ Pregnant
- ☐ Psychiatric Care
- ☐ Radiation
- ☐ Seizures
- ☐ Shingles
- ☐ Sickle Cell Disease
- ☐ Sinus Issues
- ☐ Stomach Issues
- ☐ Stroke
- ☐ Thyroid Hyper/Hypo
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other: _____

_____

Pedo Habits

- ☐ Clenching/Grinding
- ☐ Lip Sucking
- ☐ Mouth Breathing
- ☐ Nail Biting
- ☐ Nursing Bottle Habit
- ☐ Pacifier Habit
- ☐ Snoring
- ☐ Thumb/Finger Sucking

I certify to the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

Patient or Guardian: _____ **Date:** _____

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_____ **Accompanying Child Consent**
Initial I authorize the following individuals to act as appointed health care representatives with whom my child's information may be discussed. I also authorize and give consent for the following individuals to bring my child to dental appointments.

Full Name	**Relationship**
_____	_____
_____	_____

☐ **Check here if no other individual can bring your child to dental appointments.**

_____ **Photo and Video Release**
Initial I hereby grant Rock Dental Brands the right and unrestricted permission to use photos/videos taken of me (or my child), or in which I (or my child) may be included with others, and to use, reuse, publish, and republish the same in whole or in part, individually or in conjunction with other photos/videos and in conjunction with any media now or hereafter known, and for any purpose whatsoever for illustrations, promotion, art, editorial, advertising, and trade, or any other purpose whatsoever without restriction..

_____ **Appointment Policy**
Initial In order to offer the best dental services to our patients, our office reserves individual appointment times for every patient. Should something occur that requires you to break your scheduled appointment, we ask that you give a minimum of 48 hours notice for any appointment changes or cancellations, yet earlier notification is greatly appreciated. We ask that you arrive on time for your scheduled appointments. We reserve the right to charge for broken appointments when less than 48 hours notice is given. After 2 consecutive missed appointments, it is our policy to not reschedule your child for any further appointments.

If the patient is a minor, I understand that a legal guardian must be present at the new patient appointment and all treatment appointments. Any person bringing the patient to an appointment must be added to the patient's HIPAA form by the legal guardian prior to the appointment.

_____ **Text and Email Policy**
Initial You may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our team, and to provide general treatment reminders and information about our products and services. By signing below, you consent to receiving appointment reminders and other communications/information via email or text from our practice sent to any email address or phone number you provide to us. Any email or text messages we send may not be encrypted or otherwise protected and could be intercepted by a third party. You assume the risks of using email and text messages. Message and data rates may apply through your carrier.

_____ **Consent to Receive Treatment**
Initial Upon diagnosis, I authorize the doctor to perform all recommended treatment mutually agreed upon and to employ such assistance as required to provide proper care. I agree to the use of any necessary anesthetics, sedatives, and other medications. I fully understand that using any medications can involve certain risks. I understand that I can ask for a complete recital of any possible complications. The legal guardian, or biological parent MUST BE PRESENT for ALL exam and treatment appointments, including Oral conscious sedation appointments.

_____ **Notice of Privacy Policy**
Initial We care about your privacy and the privacy of your personal health information. By law, we are required to maintain your privacy, and to give you notice of our privacy policies and practices, if requested. Our Privacy Policy is displayed in our offices, can be viewed on our website, and a printed copy is available upon request. *Please list below any person who can receive PHI (Protected Health Information) on this patient.*

Name	**Relationship**	**Treatment Info**	**Ledger**
_____	_____	Yes No	Yes No
_____	_____	Yes No	Yes No

Patient Name: _____

Parent/Guardian: _____ **Date:** _____