Smiles for Kids
DENTISTRY & ORTHODONTICS

PATIENT INFORMATION

NAME: LAST_____FIRST_____MI_____SEX: M F

BIRTH DATE: _____/_____/_____ AGE: _____ SS#_____-_____-_____

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BIRTH DATE: _____/_____/_____ AGE: _____ SS#_____-_____-_____

NAME: LAST_____FIRST_____MI_____SEX: M F

BIRTH DATE: _____/_____/_____ AGE: _____ SS#_____-_____-_____

ADDRESS _____ CITY_____

STATE _____ ZIP _____ HOME PHONE _____ CELL _____

OTHER_____EMAIL_____

HEAD OF HOUSEHOLD

NAME: LAST_____ FIRST_____ MI_____ SEX: M F

BIRTH DATE: _____/_____/_____ AGE: _____ SS#_____-_____-_____ MARITAL STATUS: S M W D

ADDRESS _____ CITY_____

STATE _____ ZIP _____ HOME PHONE _____ WORK _____

CELL _____ EMPLOYER_____

NUMBER OF YEARS EMPLOYED: _____RELATIONSHIP TO PATIENT_____

SPOUSE/OTHER PARENT INFORMATION: NAME_____ EMPLOYER _____

OCCUPATION_____ SS# _____-_____-_____ BIRTH DATE _____/_____/_____

WORK PHONE _____ CELL PHONE _____

How did you hear about us?

Check boxes if you have seen us in any/all of the following:

If you have been referred, write that person or doctor's name in the space provided and we will be sure to thank them!

- ❏ My child's school received a puppet show.
- ❏ I attended an event where Smiles for Kids Dentistry, Orthodontics & Oral Surgery participated as a vendor.
- ❏ I saw a social media post about Smiles for Kids Dentistry, Orthodontics & Oral Surgery.
- ❏ I searched on Google for Smiles for Kids Dentistry, Orthodontics & Oral Surgery.
- ❏ My friend/neighbor/colleague_____ recommended Smiles for Kids Dentistry, Orthodontics & Oral Surgery.
- ❏ My dentist _____recommended Smiles for Kids Dentistry, Orthodontics & Oral Surgery.
- ❏ Other_____ _____

IT IS IMPORTANT THAT THE MEDICAL AND DENTAL INFORMATION PROVIDED IS CURRENT AND ACCURATE. FOR OUR DOCTORS TO PROVIDE SAFE AND EFFECTIVE DENTAL CARE, IT IS NECESSARY FOR THEM TO KNOW YOUR MEDICAL AND DENTAL HISTORY. THANK YOU FOR TAKING YOUR TIME TO FILL OUT THIS FORM COMPLETELY.

Medical History

Conditions

Does the patient have any MEDICAL CONDITIONS? ___YES ___NO
(For example: ADHD, Asthma, Autism, Cerebral Palsy, Diabetes, Epilepsy, Seasonal Allergies, ETC)
If YES, what conditions?
Does the patient have any HEART conditions? ___YES ___NO
(For example: Heart Murmur, congenital Heart Defects, ETC)
If YES, what conditions?
Does the patient require an ANTIBIOTIC before being seen? ___YES ___NO
If YES, did the patient take the antibiotic? ___**YES** ___**NO**
Does the patient have any history of Cancer or Kidney Disease? ___YES ___NO
If Yes, please explain:
Is there any possibility of pregnancy? ___YES ___NO

Allergies

Does the patient have an ALLERGY to LATEX? ___YES ___NO
Does the patient have any OTHER ALLERGIES? ___YES ___NO
(For example: Animals, Foods, Medications, Nickel, ETC)
If YES, what allergies?

Medications

Is the patient currently taking ANY Medications/Vitamins? ___YES ___NO
If Yes, what medications/Vitamins?
Why is the patient taking this medication (what condition is it for)?

Dental Concerns

Do you (or the patient) have any DENTAL CONCERNS? ___YES ___NO
If YES, what concerns do you have?

Surgery

Has the patient had any surgeries/hospitalizations in the past 2 years ___YES ___NO
If YES, what was the approximate date and reason?

Emergency Contact:_____ Relationship to patient:_____
Phone #:_____
I certify that the information I have given is correct to the best of my knowledge. If any changes do occur I will notify Smiles for Kids Dentistry, Orthodontics & Oral Surgery and update my file.

Signature:_____ Date:_____

DENTAL HISTORY

NAME OF PREVIOUS
DENTIST_____
PHONE_____

HOW LONG HAS IT BEEN SINCE YOU'VE SEEN A DENTIST? _____ DATE OF LAST
X-RAYS_____

HAVE YOU HAD ANY PERIODONTAL (GUM) PROBLEMS? YES NO

DO YOUR GUMS BLEED OR FEEL IRRITATED OR TENDER? YES NO

DO YOU FLOSS REGULARLY? YES NO

ARE YOUR TEETH SENSITIVE HOT SWEETS TO (PLEASE CIRCLE) COLD PRESSURE

DO YOU HAVE HEADACHES, EARACHES, OR NECK PAIN? YES NO

HAVE YOU WORN BRACES ON YOUR TEETH? YES NO

ARE YOU HAPPY WITH THE APPEARANCE OF YOUR TEETH? YES NO

If not please explain:_____

Welcome to our practice and thank you for choosing us as your dental care providers. We are committed to your treatment being successful. All patients must complete and sign our information/new patient form prior to any treatment. We ask that you please read the following office policies to familiarize yourself with our office. After reading, please sign below. Thank You.

FULL PAYMENT IS DUE AT THE TIME OF SERVICE

Estimates for major dental care are available. A monthly financial fee of 18% is applied to balances not paid by the 1st of the following month after treatment. There will be a $35.00 handling fee, in addition to any bank charges for any returned checks. For your convenience we accept cash, checks, Visa, Master Card, American Express, Discover, and Care Credit.

REGARDING INSURANCE

We must emphasize that as dental care providers, our relationship is with you and not your insurance company. Your insurance policy is a contract between you and your insurance company. Although we are happy to assist you with your insurance claims, we are not a party to that contract. In the event we do accept assignment of benefits, we require that you pay the deductible (or provide proof that you have done so) and pay the estimated portion of your bill at the time of service. We often accept assignment of insurance benefits, however the balance is your responsibility whether your insurance company pays or not. We are unable to bill your insurance company unless you give us your complete insurance information.

We allow 60 days for your insurance company to pay. In the event your insurance has not paid within a 60-day period, the bill will then be turned over to you and you will be responsible to pay within the next 30 days. At that time we also re-submit to your insurance company for the last time. A simple call to your insurance company for you will greatly facilitate the payment. Remember, payment for your dental bill is always your responsibility. We allow your insurance company 60 days to pay as a service to you. All percentages and deductibles are due in full at the time of treatment.

REMEMBER, WHAT WE COLLECT FROM YOU AT THE TIME OF VISIT IS ONLY AN ESTIMATE. AFTER RECEIVING YOUR INSURANCE PAYMENT, WE WILL BILL OR CREDIT YOUR ACCOUNT THE DIFFERENCE.

USUAL AND CUSTOMARY RATES

OUR PRACTICE IS COMMITTED TO PROVIDING THE BEST TREATMENT FOR OUR PATIENTS AND WE CHARGE WHAT IS USUALLY AND CUSTOMARY FOR OUR AREA. YOU ARE RESPONSIBLE FOR PAYMENTS REGARDLESS OF ANY INSURANCE COMPANY'S ARBITRARY, OUT-DATED DETERMINATION OF USUAL AND CUSTOMARY RATES.

APPOINTMENTS AND SCHEDULING

PLEASE REMEMBER THAT ONCE YOU MAKE AN APPOINTMENT, THE DOCTOR'S TIME, TREATMENT ROOM, AND SUPPORT PERSONNEL HAVE BEEN RESERVED SPECIFICALLY FOR YOU. WHEN WE SET ASIDE THIS RESERVED APPOINTMENT TIME FOR YOU WE WILL CONSIDER IT AS TIME YOU HAVE COMMITTED. **UNLESS CANCELLED AT LEAST 24 HOURS IN ADVANCE, OUR POLICY IS TO CHARGE $25.00 PER REGULAR APPOINTMENT, OR $50 PER SEDATION APPOINTMENT.** IF A MISSED APPOINTMENT DOES OCCUR, WE WOULD ASK YOU TO PAY YOUR MISSED APPOINTMENT FEE PRIOR TO BEING SEEN. IF A SECOND MISSED APPOINTMENT OCCURS, WE ASK THAT YOU PAY YOUR MISSED APPOINTMENT FEE PRIOR TO SCHEDULING YOUR NEXT APPOINTMENT. IF A THIRD MISSED APPOINTMENT OCCURS, WE WILL ONLY BE ABLE TO SCHEDULE SAME DAY APPOINTMENTS FOR YOU FOR NON-EMERGENCY PROCEDURES. YOU WILL BE RESPONSIBLE FOR CALLING OUR OFFICE THE DAY YOU WOULD LIKE TO COME IN FOR AN APPOINTMENT AND WE WILL LET YOU KNOW WHAT AVAILABILITY WE HAVE, IF ANY, FOR THAT PARTICULAR DAY. HOWEVER, IF YOU FAIL TO KEEP THE SAME DAY APPOINTMENT, WE WILL HAVE TO ASK YOU TO FIND ANOTHER DENTAL PROVIDER. WHEN PATIENTS FAIL TO ARRIVE FOR THE APPOINTMENTS THEY SCHEDULED, THAT TIME IS LOST AND COULD HAVE BEEN USED TO TREAT OTHER PEOPLE IN NEED. WE WOULD GREATLY APPRECIATE YOUR FULL COOPERATION IN REGARDS TO OUR OFFICES SCHEDULING POLICIES.

Every operating day, we make every effort to stay on schedule and be sensitive to our patient's time. We ask that you help us by arriving at least 5 minutes prior to your appointment. **In order to keep our office operating on time, it may be necessary to reschedule your appointment if you are more than 15 minutes late for regular appointments or 10 minutes late for sedation appointments.** If uncontrollable circumstances have occurred to make you up to 15 minutes late, there may be a possibility that you may still be seen. However, other patients that are currently scheduled will be seen first. Despite our best intent, treatment emergencies do, on occasion, arise in our schedule causing unavoidable delays. We will apprise you of any such circumstance at the earliest possible opportunity to avoid any inconvenience for you.

MINOR PATIENTS

The parent, adult, or guardian accompanying the child during the child's appointment, is responsible for full payment. For an unaccompanied minor, non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, credit card, payment by case or check at the time of service. All children must be accompanied by their legal guardian. **If an adult that is not the child's legal guardian is bringing in the child, a signed letter by the legal guardian must be presented at the day of appointment or the child will not be able to be seen**.

NITROUS

Please be aware that we use nitrous oxide for all appointments requiring anesthesia. The majority of insurances, with the exception of State Medicaid programs, DO NOT cover Nitrous Oxide. If for any reason you are not wanting to have this administered to your child, please let the office know before the day of the appointment. The parent or guardian bringing the child to the appointment **MUST** stay in the building the entire length of the appointment.

I HAVE READ THE POLICIES AND I UNDERSTAND AND AGREE TO THEM

_____ _____ _____ NAME (PLEASE PRINT) SIGNATURE OF PATIENT OR RESPONSIBLE PARTY DATE

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

H.I.P.A.A.

You may refuse to sign this acknowledgement

I,_____ , acknowledge that I have read a copy of Smiles for Kids Dentistry, Orthodontics & Oral Surgery Notice of Privacy Practices.

_____ _____ _____

Signature Date Please Print Name

FOR OFFICIAL USE ONLY

We attempted to obtain written acknowledgement of receipt of our Privacy Practices, but acknowledgment could

not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgment
- ❑ Other (Please Specify)

Patient Name(s): _____

Smiles for Kids Dentistry, Orthodontics & Oral Surgery communicates with our families in a number of ways. We use US Postal Service mail, telephone calls, and electronic communication. Electronic communication consists of email and/or text message.

Please submit your email address if you would like to receive emails for appointment reminders, or other communication needs.

Email Address 1: _____

_____

Smiles for Kids Dentistry, Orthodontics & Oral Surgery is also capable of communicating appointment reminders via text message. If you would like to participate in text message reminders, please submit the mobile number you would like to use. Standard text messaging rates will apply

Mobile Phone Number: _____

I consent to electronic communication from Smiles for Kids Dentistry, Orthodontics & Oral Surgery as outlined above. I understand that all communication is via a secure network and that standard text messaging rates will apply for the text reminders

Signature_____**Date:**_____

Dentistry for Children and Teenagers

Consent to Authorize Treatment

If anyone other than the mother, father, or legal guardian of our patient brings him/her to our office for dental care or treatment we must have written authorization. This authorization form is required for reason pertaining to HIPAA, as well as the safety of your child. Your understanding and cooperation is greatly appreciated.

You may authorize other persons to bring your child to our office and authorize dental care and treatment by filling out the following form.

Patient Name(s):
_____

I, _____hereby give permission

to _____ to bring my child(ren) to Smiles for Kids Dentistry, Orthodontics & Oral Surgery for dental examinations, cleanings and treatment.

This authorization shall be in effect

- For the date of_____
- Until revoked by me_____

Signature: _____ Date:_____

Smiles for Kids Dentistry, Orthodontics & Oral Surgery
https://www.smilesforkidsdentistry.com/

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Albuquerque, NM 87112
505-299-9606

West Pediatric Dentistry
9201 Eagle Ranch Rd NW
Albuquerque, NM 87114
505-892-9010

Oral surgery
9211 Eagle Ranch Rd NW
Albuquerque, NM 87114
505-892-9010