Bright Smiles™ of Winter Haven

Child's Name _____ Sex _____ Age _____ Birth Date _____

Nickname _____ Child S/S _____

Guarantor 1 - Relationship to Patient _____

Name _____

Home Phone _____ Cell Phone _____ Bus. Phone _____

Address _____ City/State _____ Zip _____

S/S # _____ Birthdate _____ D.L. # _____

Occupation _____ Company Name _____

Guarantor 2 - Relationship to Patient _____

Name _____

Home Phone _____ Cell Phone _____ Bus. Phone _____

Address _____ City/State _____ Zip _____

S/S # _____ Birthdate _____ D.L. # _____

Occupation _____ Company Name _____

Who does child reside with _____ Relationship _____

Telephone # to verify appointments _____ Alternate Phone _____

Mailings (post cards/reminder cards) are mailed to _____

_____ Email: _____

Please tell us how you heard about our office _____

What is the Child's Favorite Toy _____ Favorite Hobby _____

Number of Brothers _____ Sisters _____ Favorite Fictional Character _____

MEDICAL HISTORY

Child's Medical Doctor: _____ Has this child ever had any of the following (Circle those that apply)

AIDS or HIV Infection
Allergies to Anesthetics
Arthritis
Artificial Joints or Heart Valves
Asthma
Attention Deficit Disorder
Autism Spectrum Disorder
Blood Disease
Cancer
Diabetes
Developmental Disorders
Epilepsy, Seizures
Heart Murmur
Heart Problems
Hemophilia, Bleeding Problems
Hepatitis, Jaundice or Liver Disease
Intellectual Disability
Learning Problems/Delay
MRSA
Nervous Problems
Organ Transplant
Other Immunosuppressive Disorders
Pregnant
Problems with Blood Pressure
Radiation Treatment
Respiratory Disease
Rheumatic Fever
Sickle Cell Anemia
Swollen Neck Glands
Thyroid Problems

_____ **initial** **This child has not had any of the above listed conditions.**

This child has (has had) the following **condition not listed above.**

Allergies (Medicines, Drugs, Food, Other) _____

Hospitalizations (when and for treatment of what) _____

Medications being taken _____

PATIENT'S NAME _____

Do you have Dental Insurance: ☐ Yes ☐ No

Insured's Name _____

Insurance Company _____ Group # _____

DENTAL HISTORY

	Yes	No		Yes	No
Parents' Dentist _____	☐	☐	Is this your child's first visit to the dentist	☐	☐
Has child complained of any dental problems	☐	☐	Does your child brush daily	☐	☐
Any unhappy dental experiences	☐	☐	Do you assist with brushing	☐	☐
Any injuries to mouth-head-teeth	☐	☐	Is dental floss used	☐	☐
Any mouth habits (thumb/finger sucking, nail biting, mouth breathing, pacifier, etc.)	☐	☐	Is fluoride taken in any form	☐	☐
Does your child grind their teeth?	☐	☐	How do you think your child will react to dental treatment _____		
Does your child snore at night or during sleep?	☐	☐	Is there anything you would like to change about your child's smile? _____		

I consent to and authorize dental treatment for my child by the Doctors and staff at BSWH, as prescribed by the doctors. Treatment may include, but will not be limited to cleanings, fluoride treatments, x-rays, injection of medications, Nitrous Oxide (Happy Air), fillings, tooth removal, space maintenance and crowns (caps). I consent to the taking of photographs and to the use of same in scientific papers and demonstrations. I consent to dental assisting students observing and participating in the care of my child under the direct supervision of the Doctors and staff of BSWH. I have been informed that, should I not understand any explanation(s) given to me, or have questions about treatment, I am encouraged to seek clarification from the Doctors. I am aware that the Doctors will make themselves available to me to answer any questions I may have at a mutually convenient time, whether that time is before, during or after office hours. I consent to bill Dental Insurances for services rendered. I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to your use and disclosure of my protected health information to carry out payment activities in connection with this claim.

Signature of Parent or Guardian _____ Date _____

NOTES: