

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

_____ 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 _____	<input type="checkbox"/>	<input type="checkbox"/>	Is this your child's first visit to the dentist	<input type="checkbox"/>	<input type="checkbox"/>
Has child complained of any dental problems _____	<input type="checkbox"/>	<input type="checkbox"/>	Does your child brush daily	<input type="checkbox"/>	<input type="checkbox"/>
Any unhappy dental experiences _____	<input type="checkbox"/>	<input type="checkbox"/>	Do you assist with brushing	<input type="checkbox"/>	<input type="checkbox"/>
Any injuries to mouth-head-teeth _____	<input type="checkbox"/>	<input type="checkbox"/>	Is dental floss used	<input type="checkbox"/>	<input type="checkbox"/>
Any mouth habits (thumb/finger sucking, nail biting, mouth breathing, pacifier, etc.) _____	<input type="checkbox"/>	<input type="checkbox"/>	Is fluoride taken in any form _____	<input type="checkbox"/>	<input type="checkbox"/>
Does your child grind their teeth?	<input type="checkbox"/>	<input type="checkbox"/>	How do you think your child will react to dental treatment _____		
Does your child snore at night or during sleep?	<input type="checkbox"/>	<input type="checkbox"/>	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:
