SMILE DESIGNS
OF SOUTH FLORIDA, P.A.

NEW PATIENT FORM – CHILD/ ADOLESCENT

We are continually concerned with your health and the care that is rendered to you. It is therefore important to update this information on a yearly basis. If you have any questions, please feel free to ask one of our staff members to assist you. Please print clearly.

PATIENT INFORMATION

Date _____

Name of Minor/Child _____
Sex: ☐ M ☐ F Age _____ Birth Date _____ Nickname _____
Home Address _____
Street City State Zip
Childs S.S.# _____ Whom may we thank for referring you? _____

RESPONSIBLE PARTIES / INSURANCE INFORMATION

Father's/Guardian's Name _____
Address (if different from patient's) _____
_____
Home Phone _____ Work Phone _____
Employer _____

Employer Address _____

City, State, Zip _____
Union or Local _____
S.S.# _____ Birth Date _____
Do you have dental Insurance coverage for child? ☐ Yes ☐ No
Insurance Co. _____
Group # _____ Policy ID # _____
Ins. Co. Address _____
City, State, Zip _____

Mother's/Guardian's Name _____
Address (if different from patient's) _____
_____
Home Phone _____ Work Phone _____
Employer _____

Employer Address _____

City, State, Zip _____
Union or Local _____
S.S.# _____ Birth Date _____
Do you have dental Insurance coverage for child? ☐ Yes ☐ No
Insurance Co. _____
Group # _____ Policy ID # _____
Ins. Co. Address _____
City, State, Zip _____

ASSIGNMENT AND RELEASE

I, the undersigned certify that I (or my dependant) have insurance coverage with _____ and assign directly to Smile Designs of South Florida, P.A. / Julie Nordman, D.M.D., P..A. all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

_____
Signature of Guarantor

_____
Relationship to Patient

IN CASE OF EMERGENCY, CONTACT (Specify someone who does not live in your household, a relative or friend.)

Name _____ Relationship _____
Address _____
Street City State Zip
Home Phone _____ Work Phone _____ Cell Phone _____

AUTHORIZATION

I authorize the following person(s) to bring my child in for appointments and approve doctor recommended treatment. I also give this practice my permission to release the doctor's recommended future treatment to said authorized person(s):

Name _____ # _____
Name _____ # _____
Name _____ # _____

SMILE DESIGNS
OF SOUTH FLORIDA, P.A.

NEW PATIENT FORM – CHILD/ ADOLESCENT

Your child's overall health as well as any medications, which your child takes, could have an important interrelationship with the dental care your child receives. Please answer each of the following questions:

How often does your child brush? _____
How often does your child floss? _____
Is your child's water fluoridated? ☐ Yes ☐ No
Does your child take fluoride supplements? ☐ Yes ☐ No
Does your child:
Suck Thumb/Finger ☐ Yes ☐ No
Suck/Bite Lip ☐ Yes ☐ No
Bite/Chew Nails ☐ Yes ☐ No
Chew Hard objects (pencils, etc.) ☐ Yes ☐ No
Grinding teeth ☐ Yes ☐ No
Clench Jaws ☐ Yes ☐ No
Date of last dental visit _____
Previous Dentist _____
Address _____

Has your child had difficulty with previous dental visits? ☐ Yes ☐ No

Has your child has or ever had any of the following:

Asthma ☐ Yes ☐ No
Handicaps/Disabilities ☐ Yes ☐ No
Cancer ☐ Yes ☐ No
Tuberculosis ☐ Yes ☐ No
Hepatitis Type: _____ ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Rheumatic Fever ☐ Yes ☐ No
Hemophilia ☐ Yes ☐ No
Congenital Heart Defect ☐ Yes ☐ No
Abnormal Bleeding ☐ Yes ☐ No
Heart Murmur ☐ Yes ☐ No
Stomach, Liver or Kidney Problems ☐ Yes ☐ No
Convulsions/Epilepsy ☐ Yes ☐ No

Child's Physician _____ Phone _____
Address _____

Previous Hospitalizations/Surgeries/Serious Illnesses When?
_____ _____
_____ _____

Is your child currently taking any medications? ☐ Yes ☐ No
(if yes, please list) _____
Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, etc.)? ☐ Yes ☐ No
(if yes, please describe) _____
Does your child have a history of allergies to any other substances (latex, environmental, etc.)?
_____
Please explain any medical problems that your child has: _____
_____
_____

FOR COMPLETION BY THE DOCTOR

Comments on patient interview concerning medical history: _____
_____
_____
_____

Significant findings from questionnaire or oral interview: _____
_____
_____
_____

Dental management considerations: _____
_____
_____
_____

Date: _____ Doctor's Signature: _____

SMILE DESIGNS
OF SOUTH FLORIDA, P.A.

NEW PATIENT FORM – CHILD/ ADOLESCENT

MEDICAL HISTORY UPDATE:

Date	Comments	Signature

AUTHORIZATION FOR DENTAL TREATMENT

I, _____, hereby authorize and consent to any treatment or procedure or the administration of necessary anesthetics and / or x-rays which my dentist deems advisable in the diagnosis and/or treatment of this patient. By signing this medical authorization and consent, I understand that as a matter of law, it shall be conclusively presumed:

A.) that the action of my dentist in obtaining this consent from me was in accordance with an accepted standard of medical-dental practice among members of the medical-dental profession with similar training and experience in this or similar medical communities and from Information provided me by my dentist, I, under these circumstances, have at least a general understanding of the procedures, the medically accepted alternate procedures or treatments and the substantial risks and hazards inherent in the proposed treatment or procedures which are recognized among dentists in this or a similar community who perform similar treatments or procedures:

OR

B.) That I, considering all the surrounding circumstances, would have undergone such treatment or procedure had I been advised by my dentist as described in paragraph "A" above.

Executed this ____day of_____, 20 ___

Patient or authorized person on behalf of the patient:

_____
Name

_____
Signature

Witness:

_____
Name

_____
Signature

OFFICE POLICIES

PATIENT INSURANCE POLICY:
We will be happy to file your claim for you and diligently pursue insurance payment. We will also gladly answer any questions you have on your insurance, and will help you understand your benefits due to you by your insurance company.

We will accept insurance as partial payment for services. However, patients must pay their portion of co-payment (amount that insurance does not cover) at each visit that services are rendered.

We work very hard to accurately estimate the amount that an insurance company will cover on any specific procedure. However, with hundreds of insurance policies and coverages, it is impossible to know with 100% assuredness what this amount will be. After we receive final payment from an insurance company, patients will be billed for any difference between our original estimate and the actual amount paid. Of course, if insurance payment was greater than the amount anticipated, we will promptly reimburse the patient for any difference.

If after 60 days from date of service, no insurance payment has been received, the patient will be expected to pay in full. Thereafter, a fee of 1½ % interest per month (18% APR) will be applied to the patients account until payment is received in full.

BROKEN APPOINTMENT POLICY:
We practice personalized quality gentle dentistry seeing only one patient at a time. A change in our schedule affects many patients as well as the normal operations of our office. Therefore, a charge of $35.00 per scheduled hour will be due to our office for appointments broken or canceled without a 24-hour notice

DUPLICATION OF DENTAL RECORDS/ X-RAYS:
Requested copies of records and/or x-rays will be charged a nominal duplication fee as permitted by Florida State Law.

I acknowledge and understand the above office policies. I also understand that I am responsible for all the charges from services rendered to me, or any member of my family. Although I have requested the doctor to bill my insurance company on my behalf, I clearly understand that it is my responsibility to make sure the entire bill is paid within 60 days from the date of service. If for any reason, a portion of my bill is not paid within 60 days by my insurance, I will further agree to make payment in full for the remaining balance at that time,

Signed: _____

Date:_____