PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

1. Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).
2. Obtaining payment from third payers (e.g. my insurance company)
3. The day-to-day healthcare operations of your practice.

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used an disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent in writing at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date _____

Print Patient Name: _____

Relationship to Patient: _____

Print Name of Parent/Guardian: _____

Signature of Parent/Guardian: _____

We are pleased to welcome you to our practice. Please take a few minutes to fill out this form as completely as you can. If you have any questions we'll be glad to help you. We look forward to working with you in creating your beautiful smile!

Patient Information

Name: _____ Date of Birth: _____/_____/_____Age:____

Nickname: _____Male: _____Female: _____Social Security: _____-_____-_____

Address: _____City: _____State: _____Zip: _____

Home Telephone: _____-_____-_____ Whom May We Thank For Your Referral: _____

Patient's Dentist:_____ Last Check-up/Cleaning: ____/____/____

Responsible Party Information

Mother/Guardian Name: _____Date of Birth: _____/_____/_____

Social Security: _____-_____-_____ Employer: _____

Address: _____City: _____State: _____Zip: _____

Home Telephone: _____-_____-_____ Work: _____-_____-_____ Cell: _____-_____-_____

Father/Guardian Name: _____ Date of Birth: ____/_____/_____

Social Security: _____-_____-_____ Employer: _____

Address: _____City: _____State: _____Zip: _____

Home Telephone: _____-_____-_____ Work: _____-_____-_____ Cell: _____-_____-_____

Primary Insurance Coverage

Primary Insured Name: _____ Date of Birth: _____/_____/_____

Relationship to Patient: _____Social Security: _____-_____-_____

Employer: _____ Address: _____

Name of Insurance: _____Group Number:_____

Address: _____ Telephone: _____-_____-_____

Secondary Insurance Coverage

Secondary Insured Name: _____Date of Birth: _____/_____/_____

Relationship of Patient: _____Social Security: _____-_____-_____

Employer: _____ Address: _____

Name of Insurance: _____ Group Number: _____

Address: _____ Telephone: _____-_____-_____

Dental History

Reason for Dental/Orthodontic Examination: _____

Has Patient Had Previous Dental/Orthodontic Treatment/Consultation? _____

Y N Speech Problems	Y N Thumb Sucking	Y N Have Tonsils Been Removed
Y N Lip Biting	Y N Finger Biting	Y N Food Collects Between Teeth
Y N Bleeding Gums	Y N Grinding Teeth	Y N Clicking/Popping of the Jaw

Medical History

Physician's Name: _____Telephone:_____-_____-_____

Address: _____City: _____ State: _____ Zip: _____

Date of last physical exam: _____/_____/_____ Results:_____

Is patient under care of physician now Y N If yes, why _____

Has patient ever been hospitalized Y N If yes, why _____

Has patient ever had surgery Y N If yes, why _____

(Women) Are you pregnant Y N Nursing Y N Taking birth control pills Y N

Has Patient reached Puberty Y N Girl started menstruation Y N Boy-has voice changed Y N

Has the Patient had any of the following:

Y N A.I.D.S/H.I.V	Y N Cerebral Palsy	Y N Hay Fever	Y N Mental Retardation
Y N Anemia	Y N Cleft Lip /Palate	Y N Hearing Problems	Y N Rheumatic Fever
Y N Asthma	Y N Convulsions	Y N Heart Problems	Y N Sinus Problems
Y N Bladder Problems	Y N Developmental	Y N Hepatitis	Y N Thyroid Disease
Y N Blood Transfusion	Y N Diabetes	Y N Jaundice	Y N Tuberculosis
Y N Bruise Easily	Y N Epilepsy	Y N Kidney Disease	Y N Premature
Y N Cancer	Y N Fainting	Y N Liver Disease	Y N Phen Phen

Other: _____

Is Patient taking any Medication? _____ If yes, list names and purpose: _____

Are You Allergic to or had a reaction to any of the following? Please Circle

Aspirin	Barbiturates	Sedatives	Metal	Local Anesthetics	None Known
Amoxicillin	Sleeping Pills	Sulfa Drugs	Latex	Any Others: _____	

Authorization

The information that I have given is correct to the best of my knowledge. I understand that it will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my/my child's medical status. I authorize the dental/orthodontic staff to perform the necessary dental/orthodontic services for my/my child. I certify that the patient is covered by insurance with: _____. I assign directly to Smiles 4 Kids, 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 also understand that responsibility for payment for dental/orthodontic services provided in the office for me/my child is mine, due and payable at the time services are rendered unless financial arrangements have been made IN ADVANCE. I hereby authorize Smiles 4 Kids, to release all information necessary to secure the payment of benefits. I authorize the use of my signature on all my insurance submissions, whether manual or electronic. I further understand that it is my responsibility to inform this office of any changes in my/my child's insurance coverage.

Signature: _____Date: _____/_____/_____

4S & Carmel Valley
Pediatric Dentistry

Your "Smile" Questionnaire

Your Name_____**Date**_____

In order to evaluate your needs and expectations as accurately as possible, please help us by answering the following questions:

Do you feel that your teeth are (circle all responses):

Too small or short?	No	Yes
Too large or long?	No	Yes
Crooked or crowded?	No	Yes
Misshaped (uneven/pointed)?	No	Yes
Off Color?	No	Yes

Do you feel your front teeth **stick out too much ("Buck Teeth)**?
No Yes
Are there **spaces** between your teeth that you do not like?
No Yes
Is there **too much or too little gum tissue** showing when you smile? No Yes
Has there been **previous orthodontic treatment (including braces or other appliances)**? No Yes
If so, when and by whom?
_____

Is there a specific time of the day or week when you must be seen?_____

Are there other **dental issues not listed** above that you would like to discuss or have treated? No Yes (explain)
_____
_____
_____

Signature_____Relationship_____