RI _____

Patient's Name:_____ ___M ___F Date of Birth:_____
Last First MI

Phone (Home):_____ (Work)_____ (Cell)_____

Address:_____
House number Street name Apt # City State Zip

Parents'/Guardians' Name (please print):_____ Email Address (please print)_____
Please Specify: ____ Biological Parent/s ____ Legal Guardian/s ____ Foster Parent/s
Do both parents have custody? ____ Yes ____ No If no, who is the custodial parent/guardian? _____
If a non-custodial parent is denied the rights by court order to make health related decisions regarding the patient, you must provide Smile Central Dento with a copy of the documentation.

Health Information

Has the patient ever had any of the following? Please check those that apply.

___ ADHD
___ AIDS
___ Allergies _____
___ Anemia
___ Asthma
___ Autism
___ Diabetes
___ Dizziness
___ Down Syndrome
___ Epilepsy
___ Fainting
___ Glaucoma
___ Head Injuries
___ Hepatitis
___ High Blood Pressure
___ Jaundice
___ Liver Disease
___Kidney Disease
___ Mental Disorders
___ Nervous Disorders
___ Respiratory Problems
___ Rheumatic Fever
___ Rheumatism
___ Sinus Problems
___ Stomach Problems
___ Stroke
___ Ulcers
___ Venereal Disease
___ Codeine Allergy
___ Penicillin Allergy
___Amoxicillin Allergy
OTHER _____
_____
_____
_____
_____
_____
_____

Medical issues that require clearance:
___ Bone Surgery/Implants
___ Blood Disease
___ Cancer
___ Excessive Bleeding
___ Growth/Tumors
___ Heart Murmur
___ Heart Disease
___ Pace Maker
___ Pregnancy (Due Date_____)
___ Radiation Treatment/Chemo Therapy
___ Sickle Cell Anemia
___ Thyroid Problems
___ Tuberculosis

Is the patient now under the care of a physician? ___Yes ___No If yes, explain:_____

Name of Pediatrician:_____ **Phone:** _____

Name of your preferred pharmacy: _____ **Phone:** _____
Does the patient have any health problems that need clarification? ___Yes ___No If yes, explain:_____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If my child has any change in their health, I will inform the doctors at his/her next appointment without fail.

Signatures: Parent/Guardian: X_____ **DDS/DMD**_____ **Date:**_____

Insurance Information

___ Self Pay/ Cash
___ Medicaid/NJ family Care - HMO: ___United Healthcare(Americhoice) ___Amerigroup ___DentaQuest ___Horizon/Mercy
___ Private/Work Insurance (If you have private insurance, ask receptionist for Private/Work Insurance registration form).
In the event that my child's insurance does not cover the services rendered, I am aware that I am responsible for the balance.

Parent/Guardian's SS# _____ **Parent/Guardian's Signature** _____

Consent for Services

I give consent to Smile Central Dental and/or other dentists to perform the necessary dental treatment on the above mentioned patient. As a condition of the treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the cost incurred in their care and financial responsibility on the part of each patient must be determined before treatment. In consideration for the professional services rendered to me, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder. I grant permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

Signature of Parent/Guardian: X_____ **Date:**_____ **Relationship to Patient** _____

If you are a returning patient and there have been no changes since the initial completion of this form, please sign and date below confirming thi

_____ _____
Parent/Guardian's Signature Date Parent/Guardian's Signature Date

_____ _____
Parent/Guardian's Signature Date Parent/Guardian's Signature Date