NEW PATIENT FORMS

Welcome to **Smile Surfers Kids' Dentistry** and thank you for choosing **Smile Surfers** as your child's dental specialist!

PATIENT INFORMATION						
FIRST NAME	MI	LAST NAME	MALE	FEMALE	DATE OF BIRTH	AGE
			☐	☐	/ /	
			☐	☐	/ /	
			☐	☐	/ /	
			☐	☐	/ /	
			☐	☐	/ /	
			☐	☐	/ /	

PARENT & RESPONSIBLE PARTY							
WHO IS THE PERSON RESPONSIBLE FOR THIS ACCOUNT?							
☐ MOTHER	☐ STEP-MOTHER	☐ GUARDIAN	☐ _____	☐ FATHER	☐ STEP-FATHER	☐ GUARDIAN	☐ _____
FULL NAME				FULL NAME			
ADDRESS				ADDRESS			
CITY		STATE	ZIP	CITY		STATE	ZIP
HOME # - -		CELL # - -		HOME # - -		CELL # - -	
EMAIL				EMAIL			

EMERGENCY CONTACT INFO		
NAME	RELATIONSHIP TO PATIENT	PH # - -

REFERRAL INFO
HOW DID YOU HEAR ABOUT OUR OFFICE?

DENTAL INSURANCE INFORMTATION			
IS YOUR CHILD COVERED BY A PRIVATE DENTAL INSURANCE PLAN? ☐ YES ☐ NO			
IS YOUR CHILD ELIGIBLE FOR STATE MEDICAID/ PROVIDER ONE? ☐ YES ☐ NO			
PRIMARY INSURANCE		SECONDARY INSURANCE	
POLICYHOLDER'S NAME		POLICYHOLDER'S NAME	
RELATIONSHIP TO PATIENT		RELATIONSHIP TO PATIENT	
DOB	SS # - -	DOB	SS # - -
EMPLOYER		EMPLOYER	
INSURANCE NAME		INSURANCE NAME	
GROUP #	ID #	GROUP #	ID #
INSURANCE PHONE # - -		INSURANCE PHONE # - -	

I certify that the information I've provided is true and correct to the best of my knowledge. I also understand that it is my responsibility to inform this office of any changes to address, phone number, insurance or responsible party changes, or any information that may affect my account, and/or the ability to submit claims to insurance companies on my behalf.

Signature of parent or guardian_____ Date_____

Printed Name of parent or guardian _____

FINANCIAL POLICY

We are committed to your child's treatment being successful and pleasant. It is our policy to make definite financial arrangements with you before treatment starts. The following is an explanation of financial policy. Please read and sign the agreement below. A member of our team will be happy to answer any questions you may have.

Payment: Payments and/or co-payments for treatment are due at the time services are rendered. We accept cash, checks, Care Credit, and most credit cards. Please inquire at the front desk for information on our payment options.
Cash Specials: 5% discount for cash payment (does not apply to reduced fee plans, insurance or use of Care Credit).
Financial responsibility: The parent or guardian who brings the child for their visit is responsible for payment at time of visit, independent of what a divorce decree may say.
Insurance: In an effort to keep dental costs down while maintaining a high level of professional care, our financial policy is payment due at time of service. We file insurance claims as a courtesy to our patients. You are responsible for deductibles, co-payments, coinsurance and dispute resolution with your insurance company. We ask that your pay your account balance within 60 days from the date of service.
Services Not Covered: Smile Surfers Kids' Dentistry does composite (white) fillings, commonly recommends sealants, and gives fluoride treatments as part of the routine exam and cleaning. Some insurance policies have coverage limitations on these procedures. Patients will be responsible for any balance incurred as a result of a coverage limitation, co-insurance or deductible. Although your policy may state that you have 100 % coverage on either preventative or basic services be aware that your yearly deductible may apply. We ask that you pay your account balance within 60 days from the date of service.
Cancellations: Please contact us 48 hours prior to your child's appointment if you need to reschedule. If you fail to show for two scheduled appointments, you will regretfully receive a termination letter from our office.

I understand that I am responsible for the payment of all fees for dental treatment for the named patient. I understand that I am responsible for any fee not paid by the patient's dental or medical insurance.

Signature: _____ Print name: _____

Relationship to patient: _____ Date: _____

HEALTH HISTORY

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form. If you have any questions, we will be happy to assist you. We look forward to working with you in maintaining your child's dental health!

TELL US ABOUT YOUR CHILD			
Child's Name:		Preferred Name:	
Date of Birth:		Describe child's temperment:	
☐ Male ☐ Female	Age:	Grade:	Hobbies:
Name of parent/ guardian fille out this form:			

DENTAL & MEDICAL HISTORY					
Child's Physician:		Phone #:		Date of last exam:	
Has your child had or does he/she now have any of the following diseases or conditions?					
ADD/ADHD	☐ YES ☐ NO	Behavioral Problems	☐ YES ☐ NO	GI problems	☐ YES ☐ NO
AIDS/HIV	☐ YES ☐ NO	Diabetes	☐ YES ☐ NO	Kidney/Stomach disease	☐ YES ☐ NO
Anemia	☐ YES ☐ NO	Drug/Alcohol/Tobacco Use	☐ YES ☐ NO	Lung disease	☐ YES ☐ NO
Asperger's Syndrome	☐ YES ☐ NO	Ear aches/Infections	☐ YES ☐ NO	Low/High blood pressure	☐ YES ☐ NO
Autism	☐ YES ☐ NO	Epilepsy/Fainting/Seizures	☐ YES ☐ NO	Radiation/Chemotherapy	☐ YES ☐ NO
Cancer/ Tumors	☐ YES ☐ NO	Headaches/Migraines	☐ YES ☐ NO	Reflux	☐ YES ☐ NO
Cerebral Palsy	☐ YES ☐ NO	Hearing/Speech impairment	☐ YES ☐ NO	Sensory Processing Disorder	☐ YES ☐ NO
Cleft Palate	☐ YES ☐ NO	Heart disease, murmurs	☐ YES ☐ NO	Sinus problems	☐ YES ☐ NO
Childhood diseases	☐ YES ☐ NO	Rheumatic Fever	☐ YES ☐ NO	Skin disorder	☐ YES ☐ NO
Childbirth defects	☐ YES ☐ NO	Heart Valve Replacement	☐ YES ☐ NO	Thyroid disease	☐ YES ☐ NO
Cold/ Canker Sores	☐ YES ☐ NO	Hepatitis	☐ YES ☐ NO	Tuberculosis	☐ YES ☐ NO
Learning Disabilities	☐ YES ☐ NO	Hemophilia/Bleeding issues	☐ YES ☐ NO	Vision problems	☐ YES ☐ NO
If you marked yes to any of the above, please include additional information:					

Asthma ☐ YES ☐ NO	Treatment:	Last Used/ Attack:
Allergies ☐ YES ☐ NO	☐ Seasonal ☐ Metal ☐ Aspirin ☐ Sulpha ☐ Local Anesthetic ☐ Latex ☐ Penicillin/Amoxicillin ☐ Foods: _____ ☐ Other: _____	
Surgeries ☐ YES ☐ NO	For what:_____ Date: _____ For what:_____ Date: _____	
Hospitalizations ☐ YES ☐ NO	For what:_____ Date: _____ For what:_____ Date: _____	
Medications ☐ YES ☐ NO	_____	
Please list any other health concerns:		Is your child adopted? ☐ YES ☐ NO
Female Patients:	Could you be pregnant? ☐ YES ☐ NO	Are you taking birth control pills? ☐ YES ☐ NO

Signature of Parent/Guardian_____ Date _____

Provider Signature _____ Date _____

GENERAL CONSENT FOR DENTAL TREATMENT

State Law requires us to obtain consent for your child's dental treatment. Furthermore, we require your agreement to certain conditions prior to performing dental treatment on your child. Please read this form carefully and ask us about anything that you do not understand. We will be pleased to explain it.

1. **Consent for Treatment.** I hereby authorize **Jared Lothyan DDS, PLLC, and/or associate(s) hereafter Smile Surfers Kids' Dentistry**, assisted by qualified dental auxiliaries of their choice to perform upon my child (or legal ward) dental examinations, radiographs (x-rays) and diagnostic photographs, and the following dental treatment including the use of any necessary or advisable local anesthesia:

- Preventative therapies such as prophylaxis, fluoride treatment and sealants
- Treatment of disease of injured teeth with dental restorations (fillings and crowns)
- Extraction of primary and permanent teeth when deemed appropriate
- Replacement of missing teeth with dental prostheses and/or space maintainers
- Treatment of diseased or injured oral tissues (hard and/or soft)
- Treatment of malposed (crooked) teeth and/or developmental or growth abnormalities
- Use of Nitrous Oxide as recommended (see behavior management form for Risks and Benefits).
- Use of Behavior management techniques as deemed necessary by doctor or staff (see behavior management form).

2. **Release.** I also authorize Smile Surfers Kids' Dentistry to use photographs, radiographs and other treatment records which do not reveal the identity of my child for the purpose of teaching, research and scientific publication.

3. **Disclaimer.** I understand that **treatment will be explained to me along with the possible alternative methods of treatment including their advantages and disadvantages as evidenced by my signature on the exam form and/or the treatment plan**. I understand that although good results are expected, the possibility and nature of complications cannot be accurately anticipated and there can be no guarantee expressed or implied as to the result of the treatments provided. If I decide to refuse or stop dental care against the advice of Dr. Lothyan, and/or the staff at Smile Surfers Kids' Dentistry, that they shall not be held responsible for any poor or unsatisfactory outcomes resulting from this choice.

4. **Disclosure of Risk.** I understand that, even though extremely rare in occurrence, some risks are known to be associated with dental treatment procedures, anesthesia and sedation. These risks are (**Common**): bleeding, swelling, temporary numbness, infection, discoloration, nausea and vomiting; (**Uncommon**): allergic reaction, prolonged or permanent numbness, prolonged pain, fainting; and scarring. I further understand and accept that complications may require hospitalization. **I also understand that all the above risks with the exception of allergic reaction may also occur as a result of dental infection, due to a lack of treatment, if I choose to not pursue treatment for my child.** I understand that refusal to consent to treatment for my child under certain, specific circumstances may constitute neglect.

5. **Remedies.** If, for any reason, a conflict or disagreement should arise at Smile Surfers Kids' Dentistry, I will present such conflict or disagreement to Dr. Lothyan in order to resolve the problem**.** Your satisfaction is our concern and we will work hard to exceed your expectations.

6. **Electronics (Cell phones, tablets, gaming systems etc).** Please be courteous with your use of wireless electronic devices in the office. In particular, **do not photograph anyone except your own child**. **VIDEO photography is not allowed.** Outside of the waiting area, please ask permission to photograph your child so that staff members can assure that privacy laws are followed.

7. **Profanity.** Due to the nature of our practice and being a pediatric provider, the use of profanity or vulgar language is strictly prohibited. If violated you may be asked to leave and/or dismissed from the practice.

8. **Late.** If you arrive more than 10 minutes late to your scheduled appointment, you may need to be rescheduled.

I hereby state that I have read and understand this form and that my questions concerning consent and conditions for dental treatment have been answered to my satisfaction. I understand that there are information sheets available that detail the risk and benefits of each of the dental treatments which are available upon request. I understand that I have the right to be provided with answers to questions which may arise during the course of my child's treatment. I further understand this consent for treatment will remain in effect until such time that I choose to terminate it.

Patient Name(s):_____

_____

Signature of Parent/Guardian: _____ Relationship to patient: _____

Printed Name of Parent/Guardian: _____ Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF STATEMENT OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for the offices of Smile Surfers Kids' Dentistry. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services, or in the performance of office health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility.

Smile Surfers Kids' Dentistry reserves the right to change the privacy practices currently described in the Statement of Privacy Practices. If privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised state of Privacy Practices by requesting that one be mailed or otherwise transmitted to me.

ADDITIONAL DISCLOSURE INFORMATION	
In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of <u>my child's</u> Protected Healthcare Information to the person(s) identified below (other than me). (I understand that the default answer is "NO". Without indicating "YES" in answer to the each individual questions, personal protected (PHI) cannot be shared with anyone unless otherwise allowed by HIPAA rules.)	
My Spouse	☐ YES ☐ NO
Any member of my immediate family (Spouse, Children, Children's Spouses)	☐ YES ☐ NO
Any member of my extended family (Parents, Grandchildren)	☐ YES ☐ NO
Other:	☐ YES ☐ NO
Name of Patient:	
Patient Signature (If 18 years or older)	
Parent/ Guardian:	
Parent/ Guardian Signature:	Date:
Parent/ Guardian Telephone Number:	

OFFICE USE ONLY BELOW THIS LINE

ACKNOWLEDGEMENT NOT OBTAINED		
Provided Prior to Treatment?	☐ YES ☐ NO	Date Statement Provided:
Reason for not obtaining patient signature	☐	Needed more time to review Statement of Privacy Practices
	☐	Wanted to consult another person before signing
	☐	Physically unable to sign
	☐	No reason offered
	☐	Other: