

Thank you for selecting our dental team. We will always offer you the most current dental care available. To help us to better serve your family, please fill out these forms for us. Thank you for your cooperation.

The Smiles By Arnold & Associates Team

Today's Date _____

Patient Information

Child's Name _____ Preferred First Name _____
 Social Sec. # _____ Date of Birth _____ Male Female
 Address _____ City, State, Zip _____
 Home Phone # _____ E-mail _____
 School _____ Grade _____
 Hobbies/Sports _____

How did you find out about our office? (Please check) Brochure in Mail Newspaper Ad
 Newspaper Article Internet Search. Which Search Engine? _____
 Friend or Family. Whom May We Thank? _____
 Other source: _____

Responsible Party

Person Responsible for Account _____
 Relation to Child _____ Date of Birth _____
 Social Sec. # _____ Marital Status Single Married
 Address _____ City, State, Zip _____
 Home Phone _____ Cell Phone _____
 Employer _____ Occupation _____
 Business Address _____ Business Phone _____
 Is this person currently a patient in our office? Yes No

Insurance Information

Is the child covered by dental insurance? Yes No
 Insurance Company _____ Insurance Phone # _____
 Name of Insured _____ Date of Birth of Insured _____
 Social of Insured _____ Subscriber ID# _____
Does the child have secondary coverage? Yes No
 Insurance Company _____ Insurance Phone # _____
 Name of Insured _____ Date of Birth of Insured _____
 Social of Insured _____ Subscriber ID # _____

Medical Health

Child's Physician _____ Phone _____
 Date of last visit _____ Currently under physician's care? Yes No
 Reason for physician's care _____
 Has your child had any serious illnesses or operations? Yes No _____
 Has your child ever had a blood transfusion? Yes No _____
 Has your child ever taken Fen-Phen/ Redux? Yes No _____
 Has a doctor ever told you that your child needs antibiotics prior to dental work? Yes No

Please check all of the following you have had or now have:

<input type="radio"/> AIDS/HIV Positive <input type="radio"/> Anemia <input type="radio"/> Asthma <input type="radio"/> Blood Diseases <input type="radio"/> Cancer/Chemotherapy <input type="radio"/> Chicken Pox <input type="radio"/> Convulsions/Epilepsy <input type="radio"/> Cough, persistent <input type="radio"/> Cough up blood <input type="radio"/> Diabetes <input type="radio"/> Epilepsy/Seizures	<input type="radio"/> Fainting <input type="radio"/> Food Allergies <input type="radio"/> Headaches <input type="radio"/> Hearing Impairment <input type="radio"/> Heart Problems Describe _____ <input type="radio"/> Hemophilia/ Abnormal Bleeding <input type="radio"/> Immunizations current <input type="radio"/> Kidney Disease or Malfunction	<input type="radio"/> LATEX ALLERGY <input type="radio"/> Liver Disease <input type="radio"/> Respiratory Disease <input type="radio"/> Rheumatic/Scarlet Fever <input type="radio"/> Sinus Problems <input type="radio"/> Skin Rash <input type="radio"/> Spina Bifida <input type="radio"/> Thyroid Disease or Malfunction <input type="radio"/> Tonsillitis <input type="radio"/> Other _____
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Is your child allergic to Penicillin Codeine Local Anesthetic (injected) Other _____
 List of drug allergies, if any _____
 List medications your child is taking, if any _____

Finance

Payment of portions not covered by insurance is expected at each appointment. For your convenience, we offer the following methods of payment. Please check the option that you prefer. If you have any questions concerning financial arrangements, it will be our pleasure to assist you.

Cash Personal Check Visa MasterCard Discover American Express
 Credit Card #: _____ Exp. Date: _____ Security Code: _____

Authorization, Release & Agreement to Pay for Services Rendered

I authorize the dentist to release any information, including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care, to third party payers and/or health practitioners. I authorize and hereby request my insurance company to pay directly to the dentist (or the dental group) insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or on behalf of my dependents.

I understand that payment is due at the time of service. I understand that if my account reaches collection status (90 days), my account may be turned over to a collection agency. I will pay ALL costs of collection, including court costs and attorney's fees incurred for collection. Additionally, if my account reaches collection status (90 days), I agree to pay a monthly late fee in an amount equal to 1.5% of my remaining balance.

I, _____, verify all information provided on these forms is completely accurate to the best of my knowledge.

Signature of patient (or parent if minor) _____ Date _____