SMILESBYARNOLD & ASSOCIATES
Cosmetic & Family Dentistry
www.SmilesByArnold.com

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:

❍ AIDS/HIV Positive	❍ Fainting	❍ **LATEX ALLERGY**
❍ Anemia	❍ Food Allergies	❍ Liver Disease
❍ Asthma	❍ Headaches	❍ Respiratory Disease
❍ Blood Diseases	❍ Hearing Impairment	❍ Rheumatic/Scarlet Fever
❍ Cancer/Chemotherapy	❍ Heart Problems	❍ Sinus Problems
❍ Chicken Pox	Describe _____	❍ Skin Rash
❍ Convulsions/Epilepsy	❍ Hemophilia/ Abnormal	❍ Spina Bifida
❍ Cough, persistent	Bleeding	❍ Thyroid Disease or
❍ Cough up blood	❍ Immunizations current	Malfunction
❍ Diabetes	❍ Kidney Disease or	❍ Tonsillitis
❍ Epilepsy/Seizures	Malfunction	❍ Other _____

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 _____