Smile Esthetics
SCOTTSDALE

11390 E Via Linda Ste 104 Scottsdale, AZ 85259 P: 480.867.1727 F: 480.867.1791

Welcome to our practice!

Child Name _____ Birthdate _____
Gender ☐ Female ☐ Male ☐ Neutral School _____ Grade_____
Address _____City _____ State _____ ZIP _____
Preferred cell phone number_____ Preferred Email _____
How do you prefer to be contacted? ☐ Phone Call ☐ Text ☐ Email
How did you hear about us? ☐ Friend/Family ☐ Google ☐ Yelp ☐ Instagram ☐ Facebook ☐ Other
Who may we thank for referring your child to the office? _____
Person to contact in case of emergency _____ Phone # _____
Person responsible for account _____ Relation _____
Family members seen by us _____
List any sports or extracurricular activities _____

Parents' Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Significant Other

Please check one: ☐ Mother ☐ Step-Mother ☐ Guardian ☐ Other _____
Name _____ Birthdate _____
SS # _____ Driver License # _____
Address (if different than child's) _____City _____ State _____ ZIP _____
Home # _____ Cell # _____
Employer _____ Occupation _____

Please check one: ☐ Father ☐ Step-Father ☐ Guardian ☐ Other _____
Name _____ Birthdate _____
SS # _____ Driver License # _____
Address (if different than child's) _____City _____ State _____ ZIP _____
Home # _____ Cell # _____
Employer _____ Occupation _____
For Insurance purposes
Name of Subscriber _____ ID # _____
Insurance Co. Name _____ Group # _____

Information Release Authorization & Payment of Benefits Authorization

I, _____, authorize the release of any information relating to any claim to third party payers. I hereby authorize and request my insurance company to pay directly to the dentist or dental office 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 my dependents. I am aware that Smile Esthetics Scottsdale, LLC makes every effort to conform to HIPAA Privacy Regulations but that my health care information may be released in the course of coordination of treatment, obtaining payment and health care operations.

Parent or Legal Guardian Signature: _____ Date: _____

CONTINUED ON BACK

Dental & Medical History (Minor)

Child Name _____ Age _____

Dental History

First dental visit? ☐ Yes ☐ No Previous X-rays taken? ☐ Yes ☐ No Date of last X-rays _____
Previous dentist's name _____ Date of last visit _____
Any unhappy dental experiences? ☐ Yes ☐ No
Do you have well water or city water? _____
Any oral habits like pencil biting, thumbsucking, nail biting, pacifier? _____

Medical History

Child's Physician and Phone # _____ Date of last exam _____

For any **YES** answer below, please explain:

1. Is your child under the **care** of a physician (other than routine care) now? ☐ Yes, _____ ☐ No
2. Does your child take any **medications** or supplements? ☐ Yes, _____ ☐ No
3. Does your child have any **allergies** (i.e.: Penicillin, latex, etc.)? ☐ Yes, _____ ☐ No
4. Has your child ever been **hospitalized**? ☐ Yes, _____ ☐ No
5. Has your child ever had **surgery**? ☐ Yes, _____ ☐ No
6. Is there anything **artificial** in your child's body, such as pins, shunts, rods, etc.? ☐ Yes, _____ ☐ No
7. Are there any **physical** problems? ☐ Yes, _____ ☐ No
8. Are there **learning** difficulties? ☐ Yes, _____ ☐ No
9. Were there problems at or before **birth**? ☐ Yes, _____ ☐ No
10. Does your child have **bleeding** disorders? ☐ Yes, _____ ☐ No

Check (x) if your child has or has had problems with any of the following:

❑ Anemia	❑ Diabetes	❑ Heart	❑ Malignancies
❑ Asthma	❑ Epilepsy	❑ Hepatitis	❑ Rheumatic Fever
❑ Cerebral Palsy	❑ Frequent Infections	❑ HIV	❑ Thyroid
❑ Chronic Sinus	❑ Headaches	❑ Kidney	❑ Tuberculosis (TB)
❑ Convulsions	❑ Hearing	❑ Liver	

Are there any current medical treatments including medications, pending surgery, recent injuries or any other medical condition not listed above? _____

Consent to Treatment

The above information I have given is correct to the best of my knowledge and I understand it is my responsibility to inform this office of any changes in my child's medical status. As the parent or guardian of the above minor patient, I do request and authorize the performance of dental services for this patient, and the performance of any procedures or techniques the dentist may deem necessary during treatment. I authorize the administration of anesthetics or analgesics which may be deemed advisable by the dentist. I authorize other individuals with whom I have placed the care of my child, such as other family members or caregivers, to sign consent for dental treatment for my child should they bring my child to any future appointments at Smile Esthetics Scottsdale.

Parent or Legal Guardian Name: _____ Relation to patient:_____

Parent or Legal Guardian Signature: _____ Date: _____