Patient Registration: Child

GENERAL INFORMATION

Child's name: _____ Date of Birth:_____ Age: _____
FIRST MI LAST

Name you would like us to use when you visit our office: _____

Address: _____

City:_____ State: _____ Zip Code _____

Mother's Name: _____ Father's name: _____

Best telephone number to reach you or leave messages concerning your child's appointments: _____

ALTERNATE PHONE NUMBERS

Home: _____ Work: _____

Cell Phone:_____ How did you hear about our office? _____

Which form of payment do you prefer to use: ☐ Check ☐ Cash ☐ Credit Card

Family Smiles Fleming Island
1515-1 Business Center Drive
Orange Park Florida 32003
(904) 215-3323

www.familysmiles.com
info@familysmiles.com

Family Smiles Ponte Vedra
151 Sawgrass Corners Drive, Suite 102
Ponte Vedra Beach, Florida 32082
904-543-0568

MEDICAL HISTORY

Please check "yes" or "no" to indicate if your child has any of the following:

Abnormal bleeding	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Aids	☐ Yes	☐ No	HIV	☐ Yes	☐ No
Artificial valve or joints	☐ Yes	☐ No	Kidney disease	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	Liver disease	☐ Yes	☐ No
Blood disease	☐ Yes	☐ No	Mitral valve prolapse	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Nervous problems	☐ Yes	☐ No
Chemical dependency	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Psychiatric care	☐ Yes	☐ No
Heart murmur	☐ Yes	☐ No	Respiratory disease	☐ Yes	☐ No
Heart problems	☐ Yes	☐ No	Rheumatic fever	☐ Yes	☐ No
Hepatitis	☐ Yes	☐ No	Tuberculosis	☐ Yes	☐ No

Does your child smoke or use other tobacco products? ☐ Yes ☐ No

Please list any medications your child is taking:_____

_____

_____

Please check to indicate if your child is allergic to any of the following:

Aspirin	☐ Yes	☐ No	Penicillin	☐ Yes	☐ No
Codeine	☐ Yes	☐ No	Local Anesthetic	☐ Yes	☐ No
Latex	☐ Yes	☐ No			

Please list any other allergies not listed above:_____

Please indicate any other health information you would like us to know : _____

_____

_____

Parent Signature: _____ Date: _____

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TREATMENT QUESTIONNAIRE AND CONSENT FOR CHILD

When was your child's last dental visit? _____ Last cleaning? _____

Has your child had an orthodontic evaluation? _____

Has your child had orthodontic treatment in the past? _____

Do you have any specific dental concerns that you would like us to discuss with you today? _____

_____

_____

We want your child's dental experience to be a positive one. Due to the advances in patient care and technologies available today, most children do not dread going to the dentist like their parents did.

- We recommend the following to help your child have a more positive dental experience:
- Always accompany your child to the office. We generally recommend that parents stay in the waiting room during treatments. Most children will cooperate better without their parents present. Our staff will notify you if your child requests you to be present during treatment.
- Please notify our staff if you must leave the office at any time during your child's treatment. We cannot treat minor children if a parent is not present unless prior arrangements have been made. This includes children of driving age or children who are brought to the office by friends or family.
- Any child with complex dental needs will be referred to a pediatric specialist. The possible reasons for referral to the pediatric dentist include: deep decay, infection, nerve damage, need for sedation or nitrous oxide, jaw discrepancies, multiple cavities, spacing issues, and extractions.
- Our treatment recommendations are based on what is best for your child and what treatments will help them to have a healthy mouth. A treatment plan and consent for treatment signed by the parent will be required before treatment will begin. We do not base any treatment decisions on insurance reimbursements. Recommendations for any necessary treatment will include an estimate for fees for this treatment. If your child is covered by your insurance policy, we will make every effort to help you maximize your benefits. However, we do not guarantee payment for any procedure by a third party.
- According to Florida law, dentists are responsible for informing patients and obtaining informed consent. This is in an effort to avoid communication errors and misunderstandings.

I, _____, hereby authorize Dr. Mapp or Dr. Scarlett and their staff to perform an examination and any necessary x-rays, and Flouride treatment on my child, _____. I understand the responsibility for payment of dental services provided in this office for myself or any dependents on my account is mine. Unless I have insurance, I am responsible for full payment of services today. I understand the fee for the above services will not exceed: _____.

I also understand that I have the right to ask questions regarding treatment before it is completed and that I have the right to ask questions regarding fees. I understand that after the initial evaluation, I will be given further information regarding the status of my child's health including any findings, proposed procedures, benefits, risks, and alternative treatments. I understand that I may ask questions and that I may also seek a second opinion. I also realize that it is mandatory that I give as accurate and complete medical and personal history as possible.

As the parent or guardian of the above mentioned child, I have read all of the above statements.

Parent Signature: _____ Date: _____

(PERSON RESPONSIBLE FOR BILL MUST SIGN CONSENT FORM).

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Acknowledgment of Receipt of Notice of Privacy Practices

You May Refuse to Sign This Acknowledgment. The undersigned acknowledges receipt of a copy of the currently effective "Notice of Privacy Practices" for Stephanie Mapp, D.M.D., P.A. A copy of this signed, dated Acknowledgement shall be as effective as the original.

Please sign your name _____Today's Date _____

If you are the legal representative of the patient, please print the patients' name(s) and describe your authority:

_____

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer, Sandy Orton.

OFFICE USE ONLY

As privacy officer, I attempted to obtain the patient's (or representative's) signature on this Acknowledgment but did not because:

- ☐ It was emergency treatment
- ☐ I could not communicate with the patient
- ☐ The patient refused to sign
- ☐ The patient was unable to sign because _____

☐ Other (please describe) _____

Sandy Orton- privacy officer: _____

APPOINTMENT CANCELLATION POLICY

To our valued patients: When a patient has a scheduled appointment, that time is reserved ***especially for the patient***. If the patient does not keep this appointment that time is lost. Some patients have to wait several weeks for their treatment, especially if they wish to come in during the more convenient appointment times. In an effort to serve our patients most effectively, we require a 24 hour cancellation notice in order to avoid a ***cancellation fee of $25***. Patients who cancel or no-show for multiple appointments will be discharged from our practice.

Thank you,

Dr. Mapp, Dr. Scarlett, and Staff

Signature of Patient (or parent of child): _____

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