HARTLAND SMILEMAKERS (CHILD'S FORM)

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This personal information will help us give the most consideration of your time and feelings and enable us to better work with you to meet the needs of you and the patient. It is important to have complete answers. All information is, of course, confidential.

CHILD'S Name _____ Nickname _____ Birth date _____
Address _____ City_____ State _____ Zip _____
Primary Phone No. _____ Secondary Phone No. _____

*****PARENT'S INFORMATION*****
Father's Name _____Birth Date _____
Address _____ City _____State _____ Zip _____
CELL Phone No. _____Employer _____ Social Security No. _____
Emp. Name/Address _____ Phone No._____
Employee's Dental Insurance_____ Group No. _____

Mother's Name _____Birth Date _____
Address _____ City _____State _____ Zip _____
CELL Phone No. _____ Employer _____ Social Security No. _____
Emp. Name/Address _____ Phone No._____
Employee's Dental Insurance_____ Group No. _____

Step-Father's Name _____Birth Date _____
Address _____ City _____State _____Zip _____
CELL Phone No. _____Employer _____Social Security No. _____
Emp. Name/Address _____Phone No._____
Employee's Dental Insurance_____Group No. _____

Step-Mother's Name _____Birth Date _____
Address _____ City _____State _____Zip _____
CELL Phone No. _____ Employer _____Social Security No. _____
Emp. Name/Address _____Phone No._____
Employee's Dental Insurance_____Group No. _____

*****PATIENT'S DENTAL HISTORY*****
Is this the patient's first visit to a dental office? _____ If not, how long since the last visit? _____
What was done at that time? _____ Is the patient having any discomfort or pain? _____
If yes, please explain _____

*****PATIENT'S MEDICAL HISTORY*****
Has the patient ever had any serious illnesses, such as rheumatic fever, any kind of heart problem or heart murmur, diabetes, etc. If yes, please explain _____
Is patient sensitive or allergic to any food or medication? _____ If so, what? _____
Date of patient's last medical checkup _____ Is patient under treatment at present? _____
If so what for? _____ What medication does the patient take? _____

WHOM MAY WE THANK FOR RECOMMENDING YOU TO OUR OFFICE? _____

-PLEASE CONTINUE ON PAGE 2-

Please **CIRCLE** if you have had any of the following:

AIDS	Chest Pain	Heart Murmur	Liver Disease	Scarlet Fever
Anemia	Congenital Heart Lesion	Heart Surgery	Low Blood	Sinus Trouble
Artificial Heart Valve	Cold Sores	Hemophilia	Lung Disease	Stroke
Artificial Joints/Hip	Diabetes	Hepatitis A or B	Nervousness	Swelling of Feet/Ankles/Hands
Asthma	Drug Addiction	Herpes	Pacemaker	Thyroid Disease
Blood Disease	Emphysema	High blood pressure	Pain in Jaw	
Cancer	Epilepsy or Seizures	Hypoglycemia	Psychiatric Care	
Chemotherapy/Radiation	Glaucoma	Kidney Trouble	Rheumatic Fever	None of these

Is there a family history of diabetes? If yes, relationship_____

Have you ever had other serious illness not circled above? _____

FINANCIAL INFORMATION

Our office policy requires that your obligation (or **ESTIMATED** insurance copayment) be paid by *the time treatment is completed*. Please advise our receptionist if other arrangements are necessary, **BEFORE SEEING THE DOCTOR**. We will be happy to help you **ESTIMATE** your copayment based upon our previous experience of what a particular Insurance Company has paid in the past. **WE CANNOT GUARANTEE THAT YOUR DENTAL PLAN WILL PAY ANY OR ALL OF YOUR BALANCE**. **In all cases, balance's remaining after insurance has paid, will be billed to you.** We accept cash, local personal checks, money orders, VISA, Master Card, American Express, Discover and Care Credit.

I HEREBY AUTHORIZE PAYMENT DIRECTLY TO THE ABOVE-NAMED DENTIST BY MY INSURANCE CARRIER FOR SERVICES RENDERED. I AUTHORIZE THE DENTIST TO RELEASE ANY INFORMATION NECESSARY TO PROCESS CLAIMS. I AGREE TO BE RESPONSIBLE FOR ANY CHARGES NOT PAID BY MY DENTAL PLAN.

Signature _____ Date _____

SOCIAL MEDIA RELEASE FORM

I give permission to the Hartland Smilemakers for the use and disclosure of my name and photos/videos of me related to my experiences here in the HSM office. I acknowledge that my name and photos/videos will be used on social networking sites all in a positive nature through advertising to promote the HSM business. I acknowledge and agree that no payments will be made to me for use of my photos/videos and/or name. I have read this release form and agree to the above terms.

Parent or Legal Guardian Signature: _____Date: _____

I ***do not*** give the Hartland Smilemakers permission to take any photos of me or my child for social networking sites.

Parent or Legal Guardian Signature: _____Date: _____