Small Smiles, LLC

Small Smiles Medical History

Patient Name: Birth Date: Date Created:

Although dental personnel primarily treat the area in and around your mouth, your child's mouth is a part of their entire body. Health problems that your child may have, or medication that your child may be taking, could have an important interrelationship with the dentistry they will receive. Thank you for answering the

Is your child under a physician's care now?	○ Yes ○ No	If yes	
Has your child ever been hospitalized or had a major operation?	○ Yes ○ No	If yes	
Is your child taking any medications, pills, or drugs (including over the counter)? If yes, please list:	○ Yes ○ No	If yes	
Does your child have any mouth habits (ie finger/thumb sucking, lip/nail biting, pacifier)?	○ Yes ○ No	If yes	
Has your child had any unfavorable reaction from previous dental or medical care?	○ Yes ○ No	If yes	

Is your child allergic to any of the following?

☐ Penicillin	☐ Latex	☐ Sulfa Drugs	☐ Local Anesthetics
☐ Peanuts/ Peanut Butter	☐ Tree Nuts	☐ Food Dye	☐ Dairy
☐ Gluten	☐ Nickel	☐ Seasonal/Enviornmental	

Other? ○ Yes ○ No If yes

Special Needs

Does your child have any of the following?

Autism	○ Yes ○ No	Aspergers	○ Yes ○ No	Sensory Processing Disorder	○ Yes ○ No
Developmental Delay	○ Yes ○ No	Speech Delay	○ Yes ○ No	Anxiety	○ Yes ○ No
Depression	○ Yes ○ No	ADD	○ Yes ○ No	ADHD	○ Yes ○ No
Down's Syndrome	○ Yes ○ No	Speech Apraxia	○ Yes ○ No	Hearing Impaired	○ Yes ○ No
Brain Injury	○ Yes ○ No				

Other? ○ Yes ○ No If yes

Does your child, or has your child had, any of the following?

AIDS/HIV Positive	○ Yes ○ No	Hemophilia	○ Yes ○ No	Hepatitis A	○ Yes ○ No	Anaphylaxis	○ Yes ○ No
Hepatitis B or C	○ Yes ○ No	Anemia	○ Yes ○ No	Herpes	○ Yes ○ No	High Blood Pressure	○ Yes ○ No
Epilepsy or Seizures	○ Yes ○ No	Artificial Heart Valve	○ Yes ○ No	Excessive Bleeding	○ Yes ○ No	Hives or Rash	○ Yes ○ No
Hypoglycemia	○ Yes ○ No	Sickle Cell Disease	○ Yes ○ No	Asthma	○ Yes ○ No	Fainting Spells/Dizziness	○ Yes ○ No
Sinus Trouble	○ Yes ○ No	Blood Disease	○ Yes ○ No	Kidney Problems	○ Yes ○ No	Leukemia	○ Yes ○ No
Stomach/Intestinal Disease	○ Yes ○ No	Frequent Headaches	○ Yes ○ No	Liver Disease	○ Yes ○ No	Low Blood Pressure	○ Yes ○ No
Cancer	○ Yes ○ No	Thyroid Disease	○ Yes ○ No	Mitral Valve Prolapse	○ Yes ○ No	Tonsillitis	○ Yes ○ No
Cold Sores/Fever Blisters	○ Yes ○ No	Heart Murmur	○ Yes ○ No	Pain in Jaw Joints	○ Yes ○ No	Tumors or Growths	○ Yes ○ No
Congenital Heart Disorder	○ Yes ○ No	Heart Pacemaker	○ Yes ○ No	Parathyroid Disease	○ Yes ○ No	Convulsions	○ Yes ○ No
Psychiatric Care	○ Yes ○ No	Diabetes Type I	○ Yes ○ No	Diabetes Type II	○ Yes ○ No	Juvenile Arthritis	○ Yes ○ No
Pregnancy	○ Yes ○ No						

Have you ever had any serious illness not listed ○ Yes ○ No If yes

Is there anything you feel we should know about your child?

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to the patient's health. It is my responsibility to inform the dental office of any changes in medical status.

Signature of Patient, Parent or Guardian:

X Date:_____

1816 BAY SCOTT CIRCLE SUITE 104
NAPERVILLE, ILLINOIS 60540

P 630.527.8686 F 630.527.8585

DAVID L. JONES, DDS
Specialist In Pediatric Dentistry

Child's Name _____ Nickname: _____

Date of Birth _____ Age : _____ Sex: ○ Male ○ Female

Parent's Marital Status ○ Married ○ Single ○ Separated ○ Divorced ○ Widowed

Father _____ SSN _____

Mother _____ SSN _____

Person Responsible For Child's Account _____

Home Address _____

Home Phone ( ) _____ Number of Years at this Address _____

Previous Address _____

Father's Birth Date _____ Father's Cell Phone/Pager # _____

Mother's Birth Date _____ Mother's Cell Phone/Pager # _____

Father Employed by _____

Business Phone ( ) _____ Number of Years at Job _____

Mother Employed by _____

Business Phone ( ) _____ Number of Years at Job _____

Occupation (Father) _____

Occupation (Mother) _____

Name of Dental Insurance, if any _____

I.D. Number

_____

Other Children in Family (Please list names and ages)

_____

_____

Child's Physician _____ Former Dentist _____

Whom may we Thank for Referring You to Our Office _____

SMALL SMILES, LLC
FINANCIAL ARRANGEMENTS

OUR FINANCIAL POLICY

Thank you for choosing us as your pediatric dental care provider. We are committed to providing your child with the highest standards of dental care. We welcome your child into our practice and strive to make your child's dental experience positive and pleasant. In order to help maintain a good relationship with our patients, Small Smiles, LLC has adopted a written financial policy. The purpose of this policy is to eliminate confusion or misunderstanding concerning financial arrangements offered by our office.

INSURANCE PLANS

Small Smiles, LLC is not affiliated with any insurance plan and is considered an out-of-network provider. For our patients with insurance benefits, please note that although we are happy to bill your insurance carrier as a courtesy, the insurance contract exists between the carrier and the insured. **We will accept insurance assignment, but cannot guarantee payment of benefits. Information regarding your insurance benefits must be received no later than 24 hours before the scheduled appointment. If we do not receive the requested insurance information within 24 hours of your scheduled appointment, we will not be able to process the claim with your insurance carrier for you and you will be responsible for the full balance at the time of service.** We will provide you with the necessary information to submit to your insurance carrier for any possible reimbursement.

Any questions regarding your benefits should be directed to your insurance carrier.

UNACCOMPANIED MINORS

All minor patients (less than 18 years of age) must be accompanied by their parent or legal guardian on their first visit. A consent form must be signed to have a minor between the ages of 16-18 seen without their parent or legal guardian present. If under the age of 16, the patient may only be seen with a parent or legal guardian present. The parent or the legal guardian accompanying the minor is responsible for full payment.

PAYMENT

Payment is due in full at each appointment for dental services provided. We accept Visa, MasterCard, American Express, Discover, Cash, and Personal Checks when accompanied by a Driver's License or State ID. If you have dental insurance, please bring your child's insurance card to each visit. As a courtesy to patients with dental insurance, we electronically submit insurance claims. Payment is due at the time of service for all estimated portions of charges, deductible, co-pay amounts, and non-covered services. If your insurance company has not paid within 45 days, your balance is due in full.

We realize that many families are in a state of change, and sometimes the question of who is responsible for the children's dental bill is uncertain. Ultimately, the parent who requests dental services for the child is responsible for all fees incurred.

A statement of services rendered will be mailed at the end of each month. Receipt of payment is expected within 30 days from the time of service for any outstanding balance. Your account will be considered delinquent if payment is not received within 60 days from the time of service; a late fee of 1.5% per month will be assessed and will appear on any subsequent statements.

Please note that a standard fee of $50 for a hygiene appointment/$75.00 for an operatory appointment will be charged to your account for any appointments not cancelled within 24 hours of the scheduled appointment time. As a courtesy, our office will allow one failed appointment per child with no charge to your account.

A $35.00 charge will be billed to the patient's account for any check returned by the bank for any reason not paid. We will resubmit the check for payment to the bank. However, if funds are still insufficient, we will not accept further payments by check in the future.

Delinquent accounts will be sent to a collection agency, and collections fees will be added to your account. If the balance is deemed uncollectible by the collection agency after 30 days, a report will be filed with the national credit reporting agencies, which will adversely affect your credit rating.

_____ _____

Signature *Date*