COMFORT SMILES
FAMILY AND COSMETIC DENTISTRY

MINOR PATIENT INFORMATION

Date: _____ **Patient's Name:** _____
Last First Middle

Age: _____ **Sex:** Male ☐ Female ☐ **Date of Birth: (M/D/Y)**_____ **Nickname:** _____

Address: _____
Street City P.O. Box

School:_____ **Hobbies**:_____

Name of Parent/Guardian: _____ **Relationship:** _____

Parent/Guardian Email:_____ **Child's Email:** _____

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

Whom may we thank for referring you to our office? _____

DENTAL INSURANCE INFORMATION

Primary Insurance Company:_____ **Insured's Name:**_____

Group Number:._____ **ID/Certificate Number:** _____

Secondary Insurance Company:_____ **Insured's Name:**_____

Group Number:_____ **ID/Certificate Number:** _____

I authorize the insurance company or companies indicated on this form to pay to the dentist all insurance benefits otherwise payable to me for services rendered. I authorize the use of my signature on file all insurance submissions.

I authorize the dentist to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Parent/Guardian Signature: _____ **Date:** _____

EMERGENCY INFORMATION

Alternate Parent/Guardian: _____ **Relationship to Patient:** _____

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

PHOTO CONSENT

I hereby give Comfort Smiles, and any and all employees and/or agents of **Comfort Smiles,** the right and permission to use and/or publish photographs of me for art and promotional purposes including but not limited to, advertising, publicity, commercial or display of use. Also authorize my photos to be posted on social media, such as Facebook, Twitter, and the office's website page.

Release of Claims: I hereby release and discharge **Comfort Smiles** and all persons functioning under Dr. Welmilya Francis-Davis permission or authority from any legal or equitable claims including but not limited to the following: blurring of the image(s), alteration, distortion or use in composite form, libel, invasion of privacy or any claims based on the production or in the process of recording or publishing the materials.

☐ Yes, you may use the patient's photos. ☐ No, do not use the patient's photos. **Parent Signature:** _____

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MEDICAL HISTORY

Physician:_____ **Date of Last Visit**: _____
Address: _____ **Phone**: _____

Please circle Yes or No (If Yes, please fill in details)

Yes No Is the patient taking any medication? _____
Yes No Is the patient allergic to any medication? _____
Yes No History of a major illness? _____
Yes No Has the patient had any operations? _____
Yes No Ever been involved in a serious accident? _____
Yes No Have seen a physician in the last 12 months? Why? _____
Yes No Are you fully vaccinated against Covid-19? If so, which brand of vaccine did you receive?
_____
Yes No Have you tested positive for Covid-19 within 15 days? _____
Yes No Female Patients only: Has menstruation started? _____
Yes No Is the patient pregnant?_____

Circle any of the medical conditions below that the patient has had or currently has.

Abnormal bleeding/Hemophilia	Diabetes	Hepatitis/Liver problems	Pneumonia
Anemia	Dizziness	Herpes	Prolonged Bleeding
Arthritis	Epilepsy	High Blood Pressure	Radiation/Chemotherapy
Asthma or Hayfever	Gastrointestinal Disorders	HIV / Aids	Rheumatic Fever
Bone Disorders	Heart Problems	Kidney problems	Tuberculosis
Congenital Heart Defect	Heart Murmur	Nervous Disorders	Tumor or Cancer

Are there any medical conditions we have not discussed that you feel we should be aware of? _____
_____

DENTAL HISTORY

Previous General Dentist:_____ **Date of last visit**: _____
What concerns you most about the patient's teeth? _____
_____

Yes No Has the patient been told that they need antibiotics before dental procedures?
If so, why? _____
Yes No Is the patient presently in any dental pain?_____
Yes No Ever experienced any unfavorable reaction to dentistry?_____
Yes No Has the patient ever lost or chipped any teeth? _____
Yes No Have there been any injuries to the face, mouth, or teeth? _____
Yes No Is any part of the patient's mouth sensitive to temperature? Where?_____
Yes No Is any part of the patient's mouth sensitive to pressure? Where? _____
Yes No Does the patient's gums bleed when brushing? _____
Yes No Is there any type of thumb or tongue habit? _____
Yes No Is the patient a mouth breather? _____
Yes No Has the patient ever seen an orthodontist? If yes, who and when? _____
Yes No What is the patient's attitude toward receiving orthodontic treatment? _____
Yes No Has anyone in the family received orthodontic treatment?_____
How did they feel about the result? _____
Yes No Do teeth or jaws ever feel uncomfortable first thing in the morning? _____
Yes No Experience jaw clicking or popping?_____
Yes No Aware of clenching or grinding teeth during the day?_____
Yes No Experience "tension" headaches?_____
Yes No Has the patient ever experienced chronic ringing in the ears?_____
Yes No Does the patient need extra help with instructions? _____
Yes No Is the patient sensitive or self-conscious about his/her teeth? _____
Yes No What are the heights of the patient's parents? Mom_____ Dad_____
Yes No Are you aware that some appointments will be during school hours? _____

I have reviewed the information on this questionnaire, and it is accurate to the best of my knowledge. I understand that this information will be used by the dentist to help determine appropriate and healthful dental treatment. If there is any change in my medical status, I will inform the dentist. I authorize the treating dental professionals to perform necessary dental treatment on me with use of local anesthetic and needed medications.

Parent/Guardian Signature: _____ **Date:**_____

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Name of Patient: _____Date: _____

Financial Policy (For ALL Patients)

Thank you for choosing us as your dental care provider. The following describes our Financial Policy. Our office is committed to providing you with the best possible care. **Your understanding of our financial policy is an essential element of your care and service**. If you have any questions regarding any aspect of our policy, please feel free to present your question to any of our team members.

Payment for services is due at the time services are rendered.

We accept cash, debit card, and for your convenience Visa and MasterCard. Please be advised that we do not accept check payments in the office.

All minor patients must be accompanied by an adult (parent or legal guardian). The adult accompanying the minor is required to pay in accordance with our policies.

Initials: _____

Appointment Policy (For ALL Patients)

We will work hard to accommodate appointments that fit your schedule and dental needs. We ask that you **let us know about changes 48 hours in advance**. We do understand that life happens, but any missed appointment without the 48 hour call may be subject to a **$35 short notice cancellation fee**. Habitual missed appointments are grounds for dismissal from the practice.

Initials: _____

Deposit Policy (For ALL Patients)

We require a deposit of half of the treatment fee to confirm your reservation if it requires us to reserve the dentist's time for more than 1 hour. Due to the extensive amount of time our staff and doctors devote to preparing and reserving uninterrupted time for these appointments, we have to ensure that you are committed to the scheduled procedure.

Initials: _____

I have read and understand the Financial Policy, Appointment Policy, and Deposit Policy for Comfort Smiles. I agree to abide by these policies.

Signature: _____ Name (Printed): _____

Insurance Policy (For Patient's With Dental Insurance)

Please remember your insurance policy is a contract between you and your insurance company. We are not party to the specifics of your plan. As a courtesy to you, our office provides certain services, including a pre-treatment estimate which we send to the insurance company at your request. If you have any questions concerning the pre-treatment estimate and/or fees for service, it is your responsibility to have these answered prior to treatment to minimize any confusion on your behalf.
Our patients who have dental insurance are expected to pay the amount of their estimated co-pay and deductible at the time of service. Payment in advance may be required for certain treatment in order to reserve chair time and fund dental laboratory fees. Please be aware some or perhaps all of the services provided may or may not be covered by your insurance policy. Any balance is your responsibility whether or not your insurance company pays a portion.

Signature: _____

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General Consent for Treatment and Local Anesthesia

While serious complications associated with dental procedures are very rare, we would like you to be informed about possible risks or complications prior to treatment.

We also need to obtain your consent before beginning your treatment.

Procedure Complications

The following risks and or complications may occur from the use of dental injections and anesthetics. They include but are not limited to:

□ Swelling at the site of injection.
□ Bleeding at the site of injection.
□ Infection at the site of injection.
□ Discomfort at the site of injection.
□ Prolonged numbness and tingling sensation in oral cavity. These sensations are usually temporary, but can be permanent.
□ Jaw muscle cramps and spasms.
□ Jaw joint difficulty or pain radiating to the head, neck and ear.
□ Nausea and vomiting.
□ Allergic reactions.
□ Rapid or irregular heartbeat.
□ Biting of the cheek, lip and tongue after treatment resulting in swelling and discomfort.

Medication Complications

Complications from medications or prescription medication given in the office are common. To decrease your risk of potentially serious drug reactions, please provide us with the knowledge of any past drug allergies or adverse reactions. In addition, we are careful about the medications we prescribe and will not prescribe a medication unless it is absolutely necessary.

Complications may include, but are not limited to:

Allergic reactions
□ Itching or swelling
□ Difficulty breathing

Adverse reactions
□ Nausea or vomiting
□ Headaches
□ Drowsiness

Depending on the procedure, minor to moderate sensitivity of the teeth and soreness of the gums in the area that was treated is completely normal. If you have any questions or concerns after care, please do not hesitate to call our office.

I have read and understand this form and give general informed consent for dental treatment. Parents please sign if children are younger than 18.

_____	_____	_____
Patient Name (Printed)	**Signature**	**Date**