growing smiles
PEDIATRIC DENTISTRY
Carisse Corns DDS, Board Certified Pediatric Dentist

Welcome Back!

Please complete the following questions. We update our patient files every 6 months.

Patient's Name: _____ **Date of Birth:** _____

Address: _____
City **State** **Zip Code**

Who does the patient live with? ☐ **Both Parents** ☐ **Mother** ☐ **Father** ☐ **Other:** _____

Parent's/Guardian's Name: _____

Home Number: _____ **Cell/Mobile Number:** _____

Which number would you like to have appointments confirmed? ☐ **HOME** ☐ **CELL/MOBILE**

E-mail Address: _____

INDICATE CHANGES TO THE FOLLOWING (CHECK ALL THAT APPLY): *If insurance has changed, please provide a copy of the new insurance card*
☐ MARITAL STATUS ☐ INSURANCE ☐ ADDRESS/PHONE/E-MAIL ☐ PRIMARY GUARDIANSHIP ☐ MEDICATIONS

CONDITIONS	**Does the patient have any MEDICAL CONDITIONS?** ☐ Yes ☐ No (For example: ADHD, Asthma, Autism, Cerebral Palsy, Diabetes, Epilepsy, Seasonal Allergies, etc.)
	If YES, what conditions?
	Does the patient have any HEART conditions? ☐ Yes ☐ No (For example: Heart Murmur, Congenital Heart Defect, etc.)
	If YES, what conditions?
ALLERGIES	**Does the patient have an ALLERGY to LATEX?** ☐ Yes ☐ No
	Does the patient have any OTHER ALLERGIES? ☐ Yes ☐ No (For example: Animals, Foods, Medications, Nickel, etc.)
	If YES, what allergies?
MEDICATIONS	**Is the patient currently taking ANY medications/vitamins?** ☐ Yes ☐ No
	If YES, what medications/vitamins? Why is the patient taking this medication (i.e., what condition is it for)?
DENTAL CONCERNS	**Do you (or the patient) have any DENTAL CONCERNS?** ☐ Yes ☐ No
	If YES, what concerns do you have?
CONSENT FOR TODAY	**X-Rays (if needed):** ***Essential for diagnosing tooth decay and other abnormalities*** ☐ Yes ☐ No **Fluoride Application:** ***To help fight tooth decay and strengthen enamel*** ☐ Yes ☐ No

I certify the information I have given is correct to the best of my knowledge. It will be held in confidence and it is my responsibility to inform this office of changes in the patient's medical status. I authorize the dental staff to perform all necessary dental treatment the patient may need. I authorize the release of all information necessary to secure benefits otherwise payable to me. I assign directly Growing Smiles Pediatric Dentistry, PC all insurance payments otherwise payable to me. I understand I am responsible for the full balance of the account regardless of my dental benefits. In case of default, I agree to pay all reasonable costs and fees associated with the collection of the account balance, including but not limited to third party collection fees, court filing fees and attorney fees.

I acknowledge my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold the dentist or any member of the staff responsible for any action they take or do not take because of errors or omissions I may have made in the completion of this form. **I affirm my signature represents my agreement to all the above mentioned terms.**

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