

**PATIENT INFORMATION AND HEALTH HISTORY FORM**

Child’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Nickname: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B. \_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_-\_\_\_-\_\_\_\_\_ Age: \_\_\_\_\_ Sex:  M  F Grade: \_\_\_\_\_\_\_

Mother/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_-\_\_\_ -\_\_\_\_\_ Driver’s License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_

Father/Legal Guardian: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_-\_\_\_-\_\_\_\_\_ Driver’s License #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_

Who has legal custody? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Person responsible for payment of account: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are parents and child living together? \_\_\_\_\_\_\_\_ Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Member ID #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Medicaid, child’s number and county: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about us? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of person who referred you? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMERGENCY CONTACT**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mobile: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

Child’s Physician /Pediatrician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_\_\_\_\_\_

Yes No Is your child in good health? Date of last physical exam\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Has your child ever had a health problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Is your child allergic to anything? If yes, what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Is your child currently taking any medications? Please give medication, dose, and reason:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Are your child’s immunizations current? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Has your child ever been hospitalized, had general anesthesia, or emergency room visits? Please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel your child is: a slow learner progressing normally a fast learner

Please check if your child has been treated for any of the following:

Heart Disease/Murmur Asthma/breathing Pneumonia Seizures  Psychiatric Problems

Cleft lip/palate ADHD/ADD Congenital birth defects Anemia Latex Allergies

Mental delays Tuberculosis Autism Cerebral palsy Penicillin Allergies

Frequent Infections Cancer/tumors Diabetes  Shunts Other Allergies:

Liver/GI disease Endocrine/growth Kidney Disease Hepatitis \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sickle cell disease/trait Recurrent headaches AIDS/HIV Rheumatic fever \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Spina bifida Bleeding Disorders Snoring Thyroid Problems \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tonsil/adenoid problems Hemophilia High/low blood pressure Speech/Hearing/Eyesight 

Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Has any member of your child’s family had any of the above? If yes, explain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DENTAL HISTORY**

Yes No Does your child use toothpaste with fluoride?

Yes No Does your child floss?

How many times a day does the child brush? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Assisted/Supervised/Self Brushed

What is the reason for your child’s dental visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Has your child ever been to the dentist? Date of last cleaning & x-rays (if taken) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of previous dentist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Has your child experienced any unfavorable reaction from previous dental care? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Has your child had a local anesthetic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Has your child been sedated for dental treatment? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Have your child’s teeth ever been injured? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Has your child had any treatment for dental trauma? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Does your child suck a finger, thumb or pacifier? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Does your child go to bed with a bottle or sippy cup? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Yes No Does your child smoke or chew tobacco? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name and ages of other children in your family \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please check if your child is having problems with any of the following:

Cavities Toothache Sensitive teeth Mouth Breathing Trauma

Color of Teeth Orthodontics Excessive Gagging Grinding of Teeth Bleeding Gums Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**CONSENT FOR DENTAL TREATMENT**

All efforts will be made to obtain the cooperation for dental treatment from your child including warmth, friendliness, persuasion, humor and understanding. Other alternatives have been developed to gain cooperation if these don’t do the job and these are called safety steps. If your child cannot hold still during the dental visit, the dentist will take safety steps to help your child to be still. These steps are used to make sure your child and the dental staff are not hurt by disruptive behavior or uncontrollable movement. The dental staff will help the dentist keep your child and other staff from getting hurt.

These are the safety steps used to protecting your child and the dental staff:

* Tell-Show-Do
* Hand Holding/Passive Restraint
* Positive Reinforcement/Verbal Praising
* Props to Help Hold the Mouth Open
* Voice Control (May Raise/Lower Voice or Provide Directions Firmly)
* Light Physical Restraint (Holding arms down, holding head to prohibit side-to-side movement, elevating feet)
* Papoose Board/Pedi-Wrap to Hold Arms and Legs Still (Only used, if needed, in an emergency situation) Will not be used if child has asthma.

I understand that the use of safety steps will help to prevent injury from disruptive or uncontrollable movements during the dental visit. The safety steps will be used if my child cannot hold still on his/her own. Dr. Yadnay Tabares will decide to use the safety steps for the safety of my child and the dental staff.

I am the parent, legal guardian, or personal representative of the patient and there are no court orders now in effect that prevent me from signing this consent. The information listed on both sides of this form is complete and accurate. I give consent for Dr. Yadnay Tabares and office staff to perform a dental examination, dental prophylaxis, fluoride treatment, take pictures and x-rays on my child. I also acknowledge my responsibility for any professional fees incurred for dental services provided for my child. I authorized Growing Smiles Dental Care to release my child’s dental records to the insurance carrier(s) provided for insurance purpose. I affirm that the information above is correct to the best of my knowledge. I understand it is my responsibility to inform Growing Smiles Dental Care of any changes in my child’s medical status.

Parent/Legal Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dentist’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Observation Notes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Growing Smiles Dental Care

Authorization Form

Date: \_\_\_\_\_\_\_\_\_\_\_\_

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s D.O.B.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/Guardian of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ authorize the following individual(s) to bring my child listed above to Growing Smiles Dental Care on my behalf. I understand that this letter gives the following individual(s) authorization to act on my behalf in regards to the dental care of my child and to receive and discuss any and all information pertaining to the care of my child.

I authorize the following individual to consent to any and all treatment as needed and suggested by the provider. I also understand that as the parent or legal guardian of this child, I will be responsible to satisfy any financial obligation that may result from such care at the time of service.

Authorize individual(s): Individuals must be over the age of 21 and must present I.D. at the time of service)

Name: Relationship to Patient:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Authorization expires on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Growing Smiles Dental Care

Electronic Communication Authorization

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ agree that Growing Smiles Dental

Care may communicate with me electronically at the email address below

regarding my child \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

(i.e., appointment reminders, copies of x-rays)

**I am aware that there is some level of risk that third parties might be able to**

**read unencrypted emails.**

I can withdraw my consent to electronic communications by calling us at

**(813)591-1568**.

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\*\* I am responsible for providing the dental practice with any updates to my email address. \*\*

Parent/Legal Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Office Policies**

**Appointments**

We at Growing Smiles Dental Care make every effort to accommodate each patient’s schedule. Your child’s appointment is specifically saved for him/her, and changes to scheduled appointments affect other patients as well. If you arrive more than 15 minutes late to your child’s appointment, your appointment may be rescheduled. If a cancellation is unavoidable, please call the office at least 48 hours in advance so that we may give that time to another patient. Your account could possibly be charged a fee if you fail to show for your child’s appointment, or if you do not give us a 48-hour notice to cancel or reschedule your child’s appointment. All fees must be paid before we are able to reschedule your child’s appointment.

**Cell Phones**

Please be courteous and turn off or silence your cell phone before entering the clinical area.  If you need to talk on the phone we ask you to please step outside. The extra conversation carried on by others in the clinical area can be very distracting to children, preventing us from close, careful communication with each young patient. Thank you for your understanding and cooperation.

**Parent Guidelines**

We have experienced that most children do better without parents present during dental treatment. By taking on an independent role, your child will become more comfortable and trusting in us. If you choose to be present, we suggest the following guidelines to improve the likelihood of a positive experience:

1. Allow us to prepare and talk to your child prior to treatment procedure.
2. Be supportive of our dental team. We are here to make your child’s experience wonderful!
3. Please be a silent observer, supporting your child with touch. Children have a tendency to hear their parents voice above all others, which distracts them from hearing our instructions. We understand that you want to help, but you may give incorrect or misleading information.
4. Many children attempt to take control of the situation by becoming uncooperative. We have found that when the parent leaves the room, the child is more likely to settle down and listen to our instructions. Your child’s cooperation is essential in completing safe and quality dentistry. If you are asked to leave, please do so immediately.

If at any point, you feel as though the experience is too overwhelming for your child, you may ask the dentist to discontinue treatment. Please understand that the doctor may stop treatment if he/she feels as though quality dentistry cannot be completed. For the safety and privacy of all patients, other children who are not being treated should remain in the reception room with a supervising adult.

**Payments and Finance**

As a courtesy to our patients, our experienced staff will be glad to file insurance claim forms for you. We do expect you to pay for all services for your child at the time the services are rendered. If for any reason, your insurance company does not pay for any service completed, you will be responsible for the remaining balance. Please keep in mind that your dental insurance is a contract between you/your employer and the insurance company. Our office does not determine your dental benefits, but we will make all efforts to work with you and your budget if necessary. For your convenience, we accept cash and all major credit cards. We also offer outside financing through Care Credit. Growing Smiles Dental Care strives to provide your child with quality care that fits into your wallet!  Our staff will be happy to assist you with any questions you may have, including information on current promotions.

Parent/Guardian Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ACKNOWLEDGMENT OF RECIEPT OF NOTICE OF**

**PRIVATE PRACTICES**

Growing Smiles Dental Care

You may refuse to sign this acknowledgment

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have received a copy of this office’s Notice of Privacy Practices.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date

**For Office Use Only**

We attempt to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

* Individual refused to sign
* Communications barriers prohibited obtaining the acknowledgment
* An emergency situation prevented us from obtaining acknowledgment

Other (Please Specify)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_