COSMIC SMILES
Family Dentistry

ABOUT YOUR CHILD

Child's Name: _____
Last Name First M.I.

Nickname: _____ ☐ Male ☐ Female

Date of Birth: _____ Age: ____ SSN: _____

Home Address: _____

_____
City State Zip Code

Home Phone: (_____) _____

School: _____ Grade: _____

Sibling's Name: _____

PARENT INFORMATION

Mother's Name: _____

Employer: _____

Work Phone: _____

Email Address: _____

Father's Name: _____

Employer: _____

Work Phone: _____

Email Address: _____

Emergency Contact: _____

Phone/Cell: _____

DENTAL INSURANCE INFORMATION

PRIMARY CARRIER

Insured's Name: _____

Date of Birth: _____

Social Security Number: _____

Employer: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Group Plan/Policy No: _____

DENTAL INSURANCE INFORMATION

SECONDARY CARRIER

Insured's Name: _____

Date of Birth: _____

Social Security Number: _____

Employer: _____

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone: _____

Group Plan/Policy No: _____

DENTAL HISTORY

Please check the questions below if your child have/had:

- Are your child's immunizations current? ☐
- Has your child had trouble from previous dental care? ☐
- Does your child have pain in his/her jaw joint (TMJ)? ☐
- Has any type of local anesthetic ever been administered to your child? ☐
- Does your child have bad breath? ☐
- Does your child have frequent sores on lips or mouth? ☐
- Is your child experiencing any pain or sensitivity in his/her mouth or teeth? ☐

- Lip sucking / biting ☐
- Nail biting ☐
- Breathing through mouth ☐
- Clenching/grinding teeth ☐
- Thumb/finger sucking ☐
- Used pacifier ☐
- Tongue/cheek biting ☐
- Tongue thrust ☐
- Breast fed ☐
- Frequent bottle use / sleeps with bottle at night ☐

Is there any other problem not covered in this section that you would like to discuss? ☐

If yes, please specify: _____

_____

What is the primary reason for your visit today? _____

Who referred you to our office? _____

Date of last dental visit? _____ Name of dentist? _____

PATIENT NAME: _____ ACCOUNT NO. _____

MEDICAL INFORMATION

Please provide us with the name of your child's physician: _____

Physician's address: _____

Phone Number: _____ Date of Last Exam: _____

ALLERGY INFORMATION

Allergies - Are you allergic to or have you had a reaction to: To all yes responses, specify type of reaction.	Yes	No	DK		Yes	No	DK
Local anesthetics	☐	☐	☐	Metals	☐	☐	☐
Aspirin	☐	☐	☐	Latex (rubber)	☐	☐	☐
Penicillin or other antibiotics	☐	☐	☐	Iodine	☐	☐	☐
Barbiturates, sedatives, or sleeping pills	☐	☐	☐	Hay fever/seasonal	☐	☐	☐
Sulfa drugs	☐	☐	☐	Animals	☐	☐	☐
Codeine or other narcotics	☐	☐	☐	Food	☐	☐	☐
				Other	☐	☐	☐

MEDICAL HISTORY

MEDICAL HISTORY - Certain illnesses and drugs may have direct effect on the oral cavity and consequently, dental treatment. In our endeavor to render appropriate uncompromising health care, it is necessary to have the following information:

Does your child have or has your child ever had the following? If yes, Please check the questions below:

Allergies	☐	Liver problems	☐
Anemia	☐	Thyroid problems	☐
Blood Disorders	☐	Rhuematic fever or rheumatic heart disease	☐
Any abnormal or prolonged bleeding, or easily bruised	☐	Tuberculosis	☐
Asthma or other respiratory ailment	☐	Pneumonia	☐
Cancer	☐	Speech, learning, or hearing disorders	☐
Congenital heart disease	☐	Hospitalized since birth	☐
Heart Murmur	☐	*Please Specify:* _____	
Convulsions	☐	Presently taking any medications	☐
Seizures	☐	*Please Specify:* _____	
Fainting	☐	Childhood illnesses	☐
Diabetes or blood sugar problems	☐	*Please Specify:* _____	
High blood pressure	☐	Any medical condition/problems not stated above that	☐
Low blood pressure	☐	should be brought to our attention	
Immune compromised HIV AIDS	☐	*Please Specify:* _____	
Kidney problems	☐		
Bladder problems	☐		

Parent or Guardian Signature Date:

X

Doctor's Signature Date:

X

(name of child)

I hereby certify that the information provided on this form is true and correct in its entirety. Since _____ is a minor patient, signed permission from a parent or guardian is required before any necessary dental treatment can be initiated. By signing this form, I hereby grant such permission. I acknowledge my responsibility for any professional fees incurred for dental services provided to my child. I authorize Cosmic Smiles Family Dentistry to release my child's dental records to the insurance carrier(s) named on the reversed side for insurance purposes:

Signed: X _____ Date: _____

MEDICAL HISTORY

Yes No DK

Are you now under the care of a physician?..... ☐ ☐ ☐

Physician Name: ( ) Phone: Include area code

Address/City/State/Zip:

Are you in good health?..... ☐ ☐ ☐

Has there been any change in your general health within the past year?..... ☐ ☐ ☐

If yes, what condition is being treated?

Date of last physical exam:

Yes No DK

Have you had a serious illness, operation or been hospitalized in the past 5 years? ..... ☐ ☐ ☐

If yes, what was the illness or problem?

Are you taking or have you recently taken any prescription or over the counter medicine(s)? ..... ☐ ☐ ☐

If so, please list all, including vitamins, natural or herbal preparations and/or dietary supplements:

This section is for Dentist use only.

DOCTOR UPDATES

DATE:	DOCTOR Initials	Date:	DATE:	DOCTOR Initials	Date:	DATE:	DOCTOR Initials	Date:
	X			X			X	
DATE:	DOCTOR Initials	Date:	DATE:	DOCTOR Initials	Date:	DATE:	DOCTOR Initials	Date:
	X			X			X	

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SECTION A: PATIENT GIVING CONSENT

Patient Name: _____

Address: _____

Telephone: _____ E-mail: _____

Patient Number: _____ Social Security Number: _____

SECTION B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY.

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Contact Officer: **Tamara Robison, DDS, PA**
Telephone: **(239) 263-4517**
Address: **15495 Tamiami Trail N., #125, Naples, FL 34110**

Right to Revoke: You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person listed above. Please understand that revocation of this Consent will *not* affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this Consent.

SECTION C: SIGNATURE

I, _____ have had full opportunity to read and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and heath care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

SECTION D: FOR OFFICE USE ONLY

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

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement
- ❑ An emergency situation prevented us from obtaining acknowledgement
- ❑ Other (please specify) _____

Signature: _____ Date: _____

You are entitled to a copy of this consent after you sign it.

HIPAA CONSENT FORM

SECTION E: REVOCATION OF CONSENT

I revoke my Consent for your use and disclosure of my protected health information for treatment, payment activities, and healthcare operations.

I understand that revocation of my Consent will *not* affect any action you took in reliance on my Consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my Consent.

Signature: _____ Date: _____

If this Revocation of Consent is signed by a personal representative (parent/guardian) on behalf of the patient, complete the following:

Personal Representative's Name: _____

Relationship to Patient: _____

COSMIC SMILES
Family Dentistry

PATIENT NAME: _____ DATE: _____

Please read and initial the following checked items, including the acknowledgment at the bottom of the page.

❑ 1.	WORK TO BE DONE
	I understand that I am having the following work done: ❑ Fillings ❑ Bridges ❑ Crowns ❑ Extractions ❑ Impacted teeth removed ❑ General Anesthesia ❑ Root Canal(s) ❑ Other _____
❑ 2.	DRUGS AND MEDICATIONS
	I understand that antibiotics, analgesics and other medications can cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting and/or anaphylactic shock (severe allergic reaction).
❑ 3.	CHANGES IN TREATMENT PLAN
	I understand that during treatment it may be necessary to change or add procedures because of conditions found while working on the teeth that were not discovered during examination, the most common being root canal therapy following routine restorative procedures. I give my permission to the Dentist to make any/all changed and additions as necessary.
❑ 4.	REMOVAL OF TEETH
	Alternative of removal have been explained to me (root canal therapy, crowns, periodontal surgery, etc.) and I authorize the Dentist to remove the following teeth and any others necessary for reasons explained in section #3. I understand removing the teeth does not always remove all the infection, if present, and it may be necessary to have further treatment. I understand the risks involved in having teeth removed, some of which are pain, swelling, spread of infection, dry socket, loss of feeling in my teeth, lips, tongue and surrounding tissue (paresthesia) that can last for an indefinite period of time (days or months), or fractured jaw. I understand that I may need further treatment by a specialist or even hospitalization if complications arise during or following treatment, the cost of which is my responsibility.
❑ 5.	CROWNS, BRIDGES, AND CAPS
	I understand that sometimes it is not possible to match the color of natural teeth exactly with artificial teeth. I further understand that I may be wearing temporary crowns, which may come off easily and that I must be careful to ensure that they arekept on until the permanent crowns are delivered. I realize the final opportunity to make changes in my new crown, bridge or cap (including shape, fit, size and color) will be before cementation.
❑ 6.	DENTURES, COMPLETE OR PARTIAL
	I realize that full or partial dentures are artificial, constructed of plastic, metal, and/or porcelain. The problems of wearing these appliances have been explained to me, including looseness, soreness and possible breakage. I realize the final opportunity to make changes in my new dentures (including shape, size, placement and color) will be the “teeth in wax” try-in visit. I understand that most dentures require relining approximately three to twelve months after initial placement. The cost for this procedure is not included in the initial denture fee.
❑ 7.	ENDODONTIC TREATMENT (ROOT CANAL)
	I realize there is no guarantee that root canal treatment will save my tooth, and that complications can occur from the treatment and that occasionally metal objects are cemented in the tooth or extend through the root, which does not necessarily affect the success of the treatment. I understand that occasionally additional surgical procedures may be necessary following root canal treatment (apicoectomy).
❑ 8.	PERIODONTAL LOSS (TISSUE & BONE)
	I understand that I have a serious condition, causing gum and bone infection or loss and that it can lead to the loss of my teeth. Alternative treatment plans have been explained to me, including gum surgery, replacements and/or extractions. I understand that undertaking any dental procedure may have a future adverse effect on my periodontal condition.

I understand that dentistry is not an exact science and that, therefore, reputable practitioners can not fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding the dental treatment which I have requested and authorized. I have had the opportunity to read this form and ask questions. My questions have been answered to my satisfaction. I consent to the proposed treatment.

Signature of Patient _____ **Date** _____

Signature of Parent/Guardian _____ **Date** _____

Reviewed By _____ **Date** _____

Any additional consent forms, contracts or agreements should be placed at the back of this section

TREATMENT CONSENT

EXTRACTIONS

Benefits:

- Last resort for non-salvageable tooth
- Elimination of pain
- Removal of teeth that are out of position

Possible Complications:

- Fractured tooth particles may remain
- Irritation to nerves may cause temporary or permanent numbness
- Part or all of tooth may be lodged in sinus, requiring more surgery or treatment by an Oral Surgeon
- Sinus communication
- Serious infection requiring extended healing period
- Stiffness of jaw and difficulty in opening mouth for a time after treatment
- Fragile or thin jawbone may fracture
- Injury to adjacent teeth or filling
- Elimination of infection

Possible Consequences of Refusing or Postponing Recommended Treatment:

- Spread of infection
- Swelling
- Pain

Possible Alternatives:

- None

ROOT CANAL

Benefits:

- Elimination of infection
- Relief of pain
- Saving the tooth

Possible Complications:

- Perforation of root or broken files complicate completion or require treatment by Endodontist
- Undiagnosable tooth fracture can mean failure and extractions
- Undiagnosable auxiliary canal means failure and extraction or retreatment by Endodontist
- Failure of abscess to respond requiring secondary treatment by Endodontist

Possible Consequences of Refusing or Postponing Recommended Treatment

- Extraction of tooth

Possible Alternatives:

- Extraction
- Bridge work

CROWNS & CAPS

Benefits:

- Improved appearance
- Repair of a tooth that is badly broken down
- Prevention of a tooth fracturing
- Restoration of a tooth that has broken
- Elimination of a space where food gets trapped
- Holding a false tooth in place as part of a bridge
- Making a solid structure to attach a partial denture
- Repair of a tooth that can no longer be filled

Possible Complications:

- Porcelain portion of crown may fracture
- Tooth may abscess and require further treatment
- Crown may come off and require re-cementation (may not show up until later)
- Future decay may require a new crown

Possible Consequences of Refusing or Postponing Recommended Treatment:

- Tooth may fracture
- Tooth may need to be extracted
- Tooth may need a root canal in addition to crown

Possible Alternatives:

- Extraction

POST & CORE

Benefits:

- Same as Crowns

Possible Complications:

- Post may come out and require re - cementation
- Future decay may require new post
- Root fracture
- Post fracture

Possible Consequences of Refusing or Postponing Recommended Treatment:

- Weak restoration on tooth
- Tooth fracture
- Tooth may need extraction

Possible Alternatives:

- Extraction of tooth/root

BRIDGEWORK

Benefits:

- Improved appearance
- Can improve chewing
- Replaced missing teeth
- Replaced teeth that are permanent (cemented)
- Some of the same advantages as Crowns

Possible Complications:

- Same as Crowns

Possible Consequences of Refusing or Postponing Recommended Treatment:

- Teeth will drift and lean over
- May lose back teeth due to shifting
- Periodontal problems (gum disease)
- Reduced chewing efficiency

Possible Alternatives:

- Partials
- No teeth in the spaces

Signature of Patient _____ **Date** _____

Signature of Parent/Guardian _____ **Date** _____

Reviewed By _____ **Date** _____

PATIENT NAME: _____ DATE: _____

Cosmic Smiles Family Dentistry is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING THE DENTAL PROFESSIONAL.**
- **FULL PAYMENT IS DUE AT TIME OF SERVICE.**
- **WE ACCEPT CASH, CHECKS, AMERICAN EXPRESS, VISA, MASTERCARD, DISCOVER AND CARE CREDIT.**
- **COSMIC SMILES FAMILY DENTISTRY PROVIDES INSURANCE COMPANY BILLING AS A COURTESY TO OUR PATIENTS. THE PATIENT PORTION OF PARTICULAR DENTAL SERVICE(S) IS ESTIMATED AND DUE AT THE TIME OF SERVICE.**

ADULT PATIENTS

Adult patients are responsible for full payment at time of service.

MINORS ACCOMPANIED BY AN ADULT

The adult accompanying a minor, his/her parents or guardians, are responsible for full payment at time of service.

UNACCOMPANIED MINORS

The parents or guardians are responsible for full payment at time of service. Non-emergency treatment will be denied unless charges have been pre-authorized to an approved credit plan, or to Visa, MasterCard or Discover.

INSURANCE

Cosmic Smiles Family Dentistry provides insurance company billing as a *courtesy* to our patients. The patient portion of particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period. The patient may not rely upon any information provided by Cosmic Smiles Family Dentistry staff regarding his/her remaining benefit in any such benefit period.

The claims we submit to insurance companies indicate that you have assigned those benefits to Cosmic Smiles Family Dentistry. However, if you are paid by the insurance company instead of Cosmic Smiles Family Dentistry, you then become responsible for the total account balance and payment would be expected immediately.

If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.

You as a patient are always responsible for any charges that are not covered by your insurance.

MEDICARE/MEDICAID/CHAMPUS/WORKER'S COMPENSATION

If you are covered by Medicare, Medicaid, Champus, Worker's Compensation or any other government sponsored program, please discuss your payment situation with our office staff prior to date of service.

DELINQUENT PAYMENTS

It is our policy to charge finance fees at 1.5% for outstanding patient balances after the balance has been outstanding 30 days. In addition, all payments returned due to non-sufficient funds will be subject to a NSF fee of $25.00.

MISSED APPOINTMENTS

Unless cancelled at least 2 business days in advance, our policy is to charge $100.00 for missed appointments Please help us service you better by keeping scheduled appointments.

Thank you for understanding our Financial Policy. Please let us know if you have any questions or concerns.

Responsible Party Signature _____ **Date** _____

AUTHRIZATION TO ACCOMPANY MINOR

We are committed to providing the best quality clinical care and clear communication to our patients and their parent/guardian. In our practice we often have adults other than the parent/guardian accompany a child to an appointment. Individuals other than the parent/guardian are NOT allowed to approve or consent to treatment. This insures your rights and responsibilities as the responsible party are not inadvertently overstepped.

If you have a step-parent, or other relative/adult you are authorizing to accompany your child in your absence, the following form MUST be completed prior to us seeing your child. In addition, we ask that parent/guardians stay on the premises while treatment is being provided.

We take responsibility for your child's oral health with the utmost respect and are continually striving to improve our services and communication to you and your family. Thank you, again, for entrusting your child's oral health to our care.

I, _____, the legal guardian of: _____
child's DOB: _____ give full authorization to: _____
relationship _____ to accompany my child for any future dental care. I understand that I will be contacted for authorization if there are any changes in my child's treatment plan. I can be contacted at the following phone number: _____

Treatment may be withheld at the doctor's professional discretion until proper legal consent has been given.

_____ _____

(Guardian signature) (Date)