Patient Information

First Name:___________________ Middle Name:___________________Last Name: ___________________

Date of Birth:___________________________________ Gender: M___ F___

Preferred Name:____

Address:____

City:____

State:____

Zip:____

Contact Information

Mother's First & Last Name:____

Mother's Address (If different from patient):

____

____

Mother's Home Phone:____

Mother's Work Phone:____

Mother's Cell Phone:____

Mother's Email:____

Father's First & Last Name:____

Father's Address (If different from patient):

____

____

Father's Home Phone:____

Father's Work Phone:____

Father's Cell Phone:____

Father's Email:____

Name of Responsible Party:____

Name of Head of Household:_______ ____

Emergency Contact(Not a parent): ____

Emergency Contact Phone Number (Not a parent):____

Patient's Medical Doctor Name/Facility:____

Medical Doctor's Phone Number:____

PRIMARY INSURANCE

Primary Policy Holder's Name:____

Place of Employment:____

Name of Dental Insurance:____

Primary Insurance ID Number:____

Insurance Company's Phone Number:____

Group Number:____

Policy Holder's Social Security Number:____

Policy Holder's Date of Birth:____

SECONDARY INSURANCE

Secondary Policy Holder's Name:____

Place of Employment:____

Name of Dental Insurance:_ ____

Secondary Insurance ID Number:____

Insurance company's Phone Number:____

Group Number:____

Policy Holder's Social Security Number:____

Policy Holder's Date of Birth:____

MEDICAL HISTORY

Allergies (Please List ALL):

____

____

____

Medical Conditions (Please List ALL):

____
____
____

Medications (Please List ALL):

____
____
____

REFERRAL SOURCE

Who referred you to our office?____

How did you hear about Centerville Pediatric Dentistry?___________________________________

POLICIES	**YES**	**NO**
I have read and understand the Privacy Policy:	☐	☐
I have read and understand the Financial Policy:	☐	☐
I have read and understand the Attendance Policy:	☐	☐
I give permission to be contacted by text and/or email:	☐	☐

By signing below, I hereby authorize assignment of insurance rights and benefits directly to the provider for services rendered. I fully understand I am solely responsible for any balance not paid by my insurance company. I hereby authorize release of any or all medical or dental information required to process an insurance claim or to another dentist or medical doctor. I have been informed that my private information will only be disclosed in a legal manner. I attest that I have legal custody of the patient. I authorize Keep Smiling, Kids to forward x-rays and Dental history upon my request.

Printed Name:__________________________________

Relationship to Patient:_______________________________

Signature:______________________________________ Date:_______________________________

Confirmation Policy

Our office strives to be respectful of each patient's time. When patients do not show up for their scheduled appointments or are late to notify our office of a cancellation, it delays care for our patients that are waiting for treatment. For this reason, we respectfully require scheduled appointments to be confirmed in advance by 2:00 pm the business day prior. Appointments not confirmed within that time will be cancelled. Once an appointment is cancelled, we will attempt to fill that appointment time and can not guarantee that we will still be able to see your child. We accept confirmation by phone call, text message, or email. Please leave a message on our office voicemail after hours. We greatly thank you for being a valued patient and for your understanding and cooperation.

Late Policy

Our primary mission is to deliver the best and most comprehensive dental care available. An important part of the mission is making the most efficient use of our office time. We do our best to accommodate our patients and be mindful of their schedule. When a patient shows up late to the scheduled appointment it also affects other patients. If a patient is more than **10 minutes late** for an appointment, the appointment may need to be rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day if one is available. We will try to accommodate late-comers as much as possible, but we will not compromise the quality and timely care provided to our other patients.

____

Child's Name (If more than one, list all children)

____ __________________

Parent/Legal Guardian Signature Date

Keep Smiling Kids
4090 Indian Ripple Road, Unit 102
Beavercreek, OH 45440