



Wayne A. Hofflich, DDS • Fleetwood Smile Boutique
 Comprehensive Dental Medicine & Aesthetics
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Child Patient Information

Patient Name: _____
 Last First MI
 Preferred Name: _____ Male Female
 Social Security #: _____
 Birth Date: _____
 Phone (Home): _____ (Work): _____ Ext: _____
 Address: _____
 Street Apartment #
 City State Zip Code
 Parent/Guardian Name: _____
 Parent/Guardian Birth Date: _____ Parent/Guardian Social Security #: _____
 Parent/Guardian Email: _____

Health Information

Date of Last Dental Visit: _____ Date of Last Dental X-rays: _____

Has child ever had any of the following? Please check those that apply:

- | | | | |
|-----------------------|---------------------|-------------------------------------|-----------------------|
| AIDS/HIV | Excessive Bleeding | Radiation Treatment | Drug Allergies: _____ |
| Anemia | Heart Disease | Rheumatic Fever | _____ |
| Arthritis | Heart Murmur | Tuberculosis | _____ |
| Asthma | Hepatitis | Transplant/Prostheses | _____ |
| Chemical Dependencies | High Blood Pressure | Is child currently pregnant? | _____ |
| Diabetes | | Yes No | |
| Epilepsy | | If so, due date: _____ | |

Recent Surgeries? Yes No Please explain: _____

• Has child ever had: (check all that apply)
 Cavities Toothache Mouth Pain Extracted Teeth Gum Infection Braces:Dr: _____

• Has child ever had any complications following dental treatment? Yes No
 If yes, please explain: _____

• Name of primary Physician: _____ Phone: _____

• Does the child have any health problems that need further clarification? Yes No
 If yes, please explain: _____

• Medications child is taking: _____

• Child's interests and hobbies: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

 Signature of patient, parent or guardian Date: _____

Reviewed by Doctor: _____ Date: _____

Referral Information

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

Insurance Information

Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ Social Security #: _____ Group #: _____

Insured's Employer Name and Address: _____

Patient's relationship to insured: Self Spouse Child Other _____

Dental insurance company name: _____

Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients/guarantors for the costs incurred in their care. Financial responsibility on the part of each patient/guarantor must be determined before treatment.

Patients/guarantors who carry dental insurance understand that all dental services furnished are charged directly to the patient/guarantor and that he or she is personally responsible for payment of all dental services. This office will help prepare the patient's insurance forms or assist in making collections from insurance companies and will credit any such collections to the patient's account. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance companies have a wide variety of rules and exclusions of which the office may not be aware. The office staff will estimate insurance coverage to the best of their abilities but the patient/guarantor agrees that this is an estimate only, not a guarantee of coverage.

A service charge of 1½% per month (18% per annum) on the unpaid balance may be charged on all accounts exceeding 21 days, unless previously written financial arrangements are satisfied.

In consideration of the professional services rendered to my dependent, or at my request, by the Doctor, I agree to pay therefore the reasonable value of said services to said Doctor, or his assignee, at the time said services are rendered, or within five (5) days of billing if credit shall be extended. I further agree that the reasonable value of said services shall be as billed unless objected to, by me, in writing, within the time for payment thereof. I further agree that a waiver of any breach of any time or condition hereunder shall not constitute a waiver of any further term or condition and I further agree to pay all costs and reasonable attorney fees if a suit be instituted hereunder.

I grant my permission to you or your assignee, to telephone me at home or at my work to discuss matters related to this form.

I agree to have any photos taken of me to be used for education and training.

I have read the above conditions of treatment and payment and agree to their content.

Signature of patient's parent or guardian Date: _____ Relationship to Patient: _____

Reviewed by: _____ Date: _____