CDK · Smileland
Children's Dentistry & Orthodontics

Get Acquainted Questionnaire

Welcome to our office!

We feel you will be pleased with the care you will be receiving. In order to begin treatment, the following information is necessary.
Please complete fully and PRINT legibly. All information of course will be held in strict confidence. Thank you for joining our family of patients.

CONFIDENTIAL PATIENT INFORMATION

Patient Information

Patient's Name _____ DOB _____ Age _____ Sex _____

Home Phone _____ Cell Phone _____ E-mail _____

Address _____ *Apt#* _____ Work Phone _____

City _____ State _____ Zip _____ SS# _____

Patient's Employer _____ Marital Status _____

Person to Notify In Case of Emergency _____ Phone _____

Relative or Friend not Living with You _____ Phone _____

Preferred method of contact (Check all that may apply) : ☐ Cell Phone ☐ Home Phone ☐ Work Phone ☐ Text ☐ E-mail

How did you hear about this office? ☐ **Friend/Family** ☐ **Yellow Pages (** ☐ **At&T** ☐ **Valley)** ☐ **Tv** ☐ **Billboard** ☐ **Passing by** ☐ **Website** ☐ **Facebook/Google /Yelp** ☐ **Other** _____

Why are you here today? ☐ **Routine Check-Up** ☐ **Toothache** ☐ **Braces** ☐ **Improve Smile** ☐ **Other** _____

I give CDK Smileland permission to contact me with announcements, surveys and other messages._____(int.) You may opt out of these communications at any time.

We use this information to provide you with excellent treatment. We may disclose Patient Health Information (PHI) to third parties that perform services for CDK Smileland in the administration of your benefits in accordance with HIPAA. These parties are required by law to sign a contract agreeing to protect the confidentiality of you PHI. Your PHI may be disclosed to an affiliate that performs services for CDK Smileland in the administration of your benefits. Our affiliates do not sell, share or rent our patients personally identifiable information unless it is required by law, do not send any e-mail or other communication without the patients permission.

Responsible Party's Information

Please note only the parent/legal guardian can sign and consent for dental treatment for a minor patient.
A form of identification, and if needed, legal documentation must be submitted prior to any dental treatment being performed on the patient.

Parent Marital Status: ☐ **Single** ☐ **Married** ☐ **Divorced** ☐ **Widowed** ☐ **Significant other**

If divorced/separated, who is the custodial parent? (Please provide legal documentaion)

Parent/Guardian Name _____

DOB _____

Relationship to patient: ☐ **Parent** ☐ **Step Parent** ☐ **Guardian** ☐ **Other:** _____

Home Phone _____ Work Phone _____

Mailing Address _____

City _____ State _____ Zip _____

Employer _____ SS# _____

Does patient reside with parent ☐ Yes ☐ No

Does anyone other than a biological parent have legal custody? ☐ Yes ☐ No

If yes, who is the legal guardian? (Please provide legal documentation)

☐ **Mother** ☐ **Father** ☐ **Step Mother** ☐ **Step Father** ☐ **Guardian** ☐ **Other** _____

Parent/Guardian Name _____

DOB _____

Home Phone _____ Work Phone _____

Mailing Address _____

City _____ State _____ Zip _____

Employer _____ SS# _____

Does patient reside with parent ☐ Yes ☐ No

Dental Insurance ☐ Yes ☐ No

Name of Subscriber _____

Does patient reside with parent ☐ Yes ☐ No

Relationship to patient _____

SS# _____ DOB _____

Employer _____ Phone Number _____

Insurance Name _____

Secondary Dental Insurance ☐ Yes ☐ No

Name of Subscriber _____

Does patient reside with parent ☐ Yes ☐ No

Relationship to patient _____

SS# _____ DOB _____

Employer _____ Phone Number _____

Insurance Name _____

Consent To Financial Responsibility

This is to certify that I, the undersigned, consent to the performing of whatever dental services and/or surgical procedures may be decided upon to be necessary or advisable, and to the use of local or general anesthetic as may be deemed advisable by the dentist. I have also been explained the consequences of partial and/or no treatment. I hereby authorize my dentist to release any and all medical information (including dental information) to the above-named insurance carrier for purposes of claims administration, evaluation, utilization, review, and financial audit. This authorization remains valid and effective from the date of signing until revoked in writing.

I hereby authorize my insurance carrier to pay directly to the within named dentist(s) the dental benefits otherwise payable to me. I understand if my insurance company does not pay in full, I am responsible for the remaining balance. I understand some dental services I receive may require a co-payment from me. The amount of the co-payment will vary according to the insurance /dental plan I have and the procedure that is performed. If my insurance/dental plan has a yearly deductible, I understand it must be satisfied before treatment begins. I also understand co-payments must be paid in full at the time of treatment. A finance charge of 1.5 % per month (18% per annual) will be charged on the unpaid principal balance on all accounts not paid within 30 days of the date of service.

I further understand dental services not covered by my insurance/dental plan may be prescribed in certain cases by the attending dentist. Usual, customary and reasonable fees will be charged for such services.

I also understand there will be a charge for any missed appointment which is not canceled within 24 hours in advance.

Patient/Guardian Signature _____ **Date** _____

Responsible Party Signature _____ **Date** _____

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Name of Patient	Date of Birth

These questions are for your benefit and assure that treatment will take into consideration your past and present health status. Some questions may seem unrelated to your dental concern, but they are all associated with proper oral health care. Please answer each question and mark YES or No as appropriate.

Medical History (If patient is a minor, parent/guardian must answer the following questions pertaining to the patient's health.)

	Yes	No
1. Are you in good health?	☐	☐
2. Are you now under the care of a physician?	☐	☐
If so, what is the condition being treated? _____		
Physician name/ phone # / address _____		
3. Have you ever had any serious illness or operation?	☐	☐
If so, what illness or operation? _____ *Date:* _____		
4. Have you ever been hospitalized?	☐	☐
If so, what was the problem? _____ *Date:* _____		
5. Are you taking medicine? Or any recreational drugs (ecstasy, cocaine, etc)	☐	☐
If so, what? _____ What dosage? _____		
6. Are you sensitive or allergic to any drugs? ☐ Penicillin ☐ Tetracycline ☐ Sulfa Drugs ☐ Aspirin ☐ Codeine	☐	☐
Other : If other, what drug(s)? _____		

7. Do you have, or have you had any of the following :

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Heart Murmur	☐	☐	Joint Replacement	☐	☐	Epilepsy or Seizures	☐	☐	Anemia	☐	☐	Liver Disease
☐	☐	High Blood Pressure	☐	☐	Allergies or Hives	☐	☐	Heart Ailments or Attack	☐	☐	Ulcers	☐	☐	Sinus Trouble
☐	☐	Radiation Therapy	☐	☐	Cortisone Medicine	☐	☐	Hepatitis	☐	☐	Glaucoma	☐	☐	Blood Disease
☐	☐	Rheumatic Fever	☐	☐	Excessive Bleeding	☐	☐	Fainting Spells or Seizures	☐	☐	Arthritis	☐	☐	Drug Addiction
☐	☐	Tuberculosis (TB)	☐	☐	Latex Allergy	☐	☐	Chemotherapy (Cancer, Leukemia)	☐	☐	Emphysema	☐	☐	Kidney Disease
☐	☐	Cardiac Pacemaker	☐	☐	Pain in Jaw Joints	☐	☐	Venereal Disease (Syphilis, Gonorrhea)	☐	☐	Cold Sores	☐	☐	HIV/AIDS
☐	☐	Nervous Disorders	☐	☐	Respiratory Disease	☐	☐	Artificial Prosthesis	☐	☐	Bruise Easily	☐	☐	Asthma
☐	☐	Thyroid Disease	☐	☐	Mental Disorder	☐	☐	Angina Pectoris	☐	☐	Head Injuries	☐	☐	Hemophilia
☐	☐	Tumors or Growths	☐	☐	Psychiatric Treatment	☐	☐	Congenital Heart Lesions	☐	☐	Diabetes	☐	☐	Stroke
☐	☐	Blood Transfusion	☐	☐	Cerebral Palsy	☐	☐	Heart Surgery (Valve Replacement)	☐	☐	Prosthetic Joints	☐	☐	Jaundice

	Yes	No
8. Do you have any disease, condition or problem not listed that you think we should know about?	☐	☐
If so what? _____		
9. Do you smoke? If yes, how much per day?	☐	☐

	Yes	No		Yes	No
10. Are you currently taking, or have you ever taken the drug Phen-Phen?	☐	☐	11. (Women) Is there a possibility you may be pregnant?	☐	☐
12. (Women) Do you have any problems associated with your menstrual period?	☐	☐	13. (Women) Do you take birth control pills?	☐	☐

Dental History

1. Have you previously attended any of our other offices?	☐	☐
☐ Smileland (Ming) ☐ Smileland (Bernard) ☐ Smileland (Delano) ☐ Smileland(Tulare) ☐ Smileland (Visalia) ☐ Smileworld ☐ Comfort Dental Orthodontics(Ming)		
2. Have you ever had a local anesthetic (Novocaine etc)?	☐	☐
3. Have you ever had an unfavorable reaction from a local anesthetic?	☐	☐
4. Have you had any serious trouble associated with any previous dental treatment?	☐	☐
If so, explain : _____		
5. How long since your last full mouth X-rays? _____		
6. How long since your last dental treatment? _____		
7. Is any current dental problem the result of an accident? ☐ Yes ☐ No When _____		
8. Does dental treatment make you nervous? ☐ No ☐ Slightly ☐ Moderately ☐ Extremely		

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

Patient/Guardian Signature : _____	Date : _____	DDS Signature : _____	Date : _____
Patient/Guarding Signature : _____	Date : _____	DDS Signature : _____	Date : _____
Patient/Guarding Signature : _____	Date : _____	DDS Signature : _____	Date : _____
Patient/Guarding Signature : _____	Date : _____	DDS Signature : _____	Date : _____
Patient/Guarding Signature : _____	Date : _____	DDS Signature : _____	Date : _____

DDS NOTES