Leesburg SMILES
GENERAL & FAMILY DENTISTRY

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www.WildwoodSmiles.com
Email: LeesburgSmiles44@gmail.com

To help us better serve you, please complete the following forms to the best of your ability.
If you have questions, do not hesitate to let us know!
Thank you for letting us be a part of your smile!

Child's Name: _____ DOB (MM/DD/YYYY): _____

Nickname: _____ Age: _____ Social Security #: _____

Gender: ☐ Male ☐ Female ☐ Other _____

Home Address: _____

City, State, Zip: _____ Phone Number: _____

Who can we thank for referring you to us? _____

How have you heard about us? _____

PARENT/FOSTER PARENT/LEGAL GUARDIAN Information (Mother/Guardian)

Name: _____ Relationship: _____

DOB (MM/DD/YYYY): _____ Social Security #: _____

Email Address: _____

Home Address (if different than above): _____

City, State, Zip: _____ Cell Phone Number: _____

Text Reminders for Appointments: ☐ Yes or ☐ No

PARENT/FOSTER PARENT/LEGAL GUARDIAN Information (Father/Guardian)

Name: _____ Relationship: _____

DOB (MM/DD/YYYY): _____ Social Security #: _____

Email Address: _____

Home Address (if different than above): _____

City, State, Zip: _____ Cell Phone Number: _____

Text Reminders for Appointments: ☐ Yes or ☐ No

PRIMARY DENTAL INSURANCE

Insurance Company: _____ Insured Name: _____

Relationship to Patient: _____ DOB: _____ Social Security #: _____

Employer: _____ Subscriber ID#: _____ Group#: _____

SECONDARY DENTAL INSURANCE

Insurance Company: _____ Insured Name: _____

Relationship to Patient: _____ DOB: _____ Social Security #: _____

Employer: _____ Subscriber ID#: _____ Group#: _____

FLUORIDE CONSENT

Most insurance companies cover fluoride treatment twice a year; however, some insurance companies only pay for fluoride application once a year.

PLEASE CHOOSE ONE (1) OF THE FOLLOWING

I, _____, give my consent to apply fluoride treatment TWICE a year. I agree that if my insurance company does NOT pay for the second application, that I am financially RESPONSIBLE for payment

I, _____, give my consent to apply fluoride treatment only ONCE a year

I, _____, do not wish fluoride treatment to be applied to my child at any time.

FINANCIAL ARRANGEMENTS/INSURANCE AGREEMENT

I authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I understand that my insurance company may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my dependent's behalf. I agree to be responsible for all fees incurred in attempting to collect these fees.

Any unpaid balance due (as listed on a billing statement), not paid within 28 days of the monthly billing date, will be assessed a late charge of 15% each month. I realize that failure to keep this account current may result in my children being unable to receive additional dental services except for dental emergencies or when there is pre-payment for additional services. In the default on payment of this account (payment due over 60 days), I agree to pay additional collection cost (33% of the unpaid balance), postage, attorney and court fees incurred in attempting to collect on this amount or any future outstanding balances.

I hereby authorize the office to contact the designated phone numbers and/or email address listed in the patient's account. With this authorization, a message/communication may be left indicating appointment time and dates, reminders, balances due, and/or estimated co-pays for future visits.

Financially responsible person for account _____

_____ _____

Signature of Parent or Legal Guardian Date

☐ Child in foster care – Children & Youth and Foster Parents will not sign Staff Initials _____

DENTAL HISTORY

Is this your child's first visit to a dentist? Yes or No

Previous Dentist: _____ **City**: _____

Date Last Seen: _____ **Date Last X-Rays**: _____

Reason for Today's Visit: _____

Any injury to your child's teeth or jaws (falls, blows, chips, etc.) Yes or No

Does your child have a history of: (Please check all that apply)

☐ Thumb sucking ☐ Lip sucking ☐ Pacifier

☐ Finger sucking ☐ Nail biting

Has your child experienced any unfavorable reaction from previous medical or dental care? Yes or No

If so, please describe: _____

How do you think your child will act towards the dentist? _____

Age of child when discontinued bottle or nursing? _____

PREVENTATIVE DENTAL HISTORY

How often does your child brush? _____ **Is toothbrushing supervised?** Yes or No

If yes, by whom and when: _____

Is dental floss used? Yes or No

Does your child receive: ☐ Fluoride in Vitamins ☐ Fluoride Tablets/Drops ☐ Fluoridated Water

If yes, how often? : _____ ☐ None

PERMISSION FOR OTHERS TO ESCORT CILD TO DENTAL APPOINTMENTS

We understand there may be times when you are unable to attend your child's dental appointment. To help make your visit as prompt and pleasant as possible, pleae provide the following information.

I, _____, hereby give the following indivual(s) my permission to bring my child(ren) to the practice and, in effect, have access to private information about their treatment. I recognize tha during the course of thetreatment unforeseen circumstances may necessitate additional or different procedures form those discussed. I hereby authorize the listed individual(s) to consent to the performance of any additional procedures that are deemed necessary or desirable to my child's oral health and well-being in the professional judgement of the dentists. I authorize the company and its employees to discuss all dental and medical information with the following individual(s) listed below.

Name of Individual _____ **Relationship to Patient** _____

Name of Individual _____ **Relationship to Patient** _____

Name of Individual _____ **Relationship to Patient** _____

_____ _____ _____

Signature **Printed Name** **Date**

MEDICAL HISTORY

1. Has your child been under the care of a medical doctor during the past two years? Yes or No

   If yes, for what? _____

   Physician's name _____ Phone _____

   Address _____

2. Has your child taken any medications or drugs during the past two years? Yes or No
3. Does your child have any allergic or adverse reactions to medications or substance? Yes or No

   List them here: _____
4. Has your child been a patient in the hospital during the past five years? Yes or No

   If so, explain here, _____
5. Indicate which of the following you have had OR have at the present. Circle "yes" or "no"

ADD/ ADHD	Yes	No	Congenital Birth Defects	Yes	No	Kidney/Liver Involvement	Yes	No
AIDS/ARC/HIV	Yes	No	Congenital Heart Disease	Yes	No	Kidney Trouble	Yes	No
Allergies	Yes	No	Contact Lenses	Yes	No	Latex Sensitivity	Yes	No
Allergy or Sensitivity to Anesthesia	Yes	No	Diabetes	Yes	No	Leukemia	Yes	No
Anemia	Yes	No	Drug Sensitivities	Yes	No	Lung Problems	Yes	No
Artificial Joints	Yes	No	Epilepsy	Yes	No	Nervous System Issues	Yes	No
Artificial Prosthesis	Yes	No	Fractured Jaw	Yes	No	Osteoporosis/penia	Yes	No
Asperger's	Yes	No	Recurrent Headaches	Yes	No	Premature Birth	Yes	No
Asthma	Yes	No	Hearing Impairment	Yes	No	Psychiatric Care	Yes	No
Autism	Yes	No	Heart Murmurs	Yes	No	Seizures / Convulsions	Yes	No
Bleeding Problems	Yes	No	Heart Trouble	Yes	No	Sinus Trouble	Yes	No
Blood Disorders	Yes	No	Hemophilia	Yes	No	Speech Problem	Yes	No
History of Blood Transfusions	Yes	No	Hepatitis A B C	Yes	No	Thyroid Problems	Yes	No
Brain Injury/Concussion	Yes	No	High Blood Pressure	Yes	No	Tuberculosis	Yes	No
Chemo/ Radiation Therapy	Yes	No	High Temperatures	Yes	No	Tumors	Yes	No
Cold Sores/Fever Blisters	Yes	No	Yellow Jaundice	Yes	No	Vision Problems	Yes	No

Is there anything else regarding your child's physical, mental, or emotional health you feel we should know?

If so, please advise: _____

I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I have answered all the questions to the best of my ability and knowledge. Should further information be needed, you have my permission to ask the respective health care provider or agency, who may release such information to you. I will notify the doctor of any change in my health or medications.

Parent/Guardian Signature _____ Date _____

Doctor Signature: _____ Date _____

MEDICINE CHART

NAME: _____ DATE: _____

Name of Medicine	What is it for?	Dosage	Prescribing Doctor	Special Instructions

OVER-THE-COUNTER MEDICATIONS:

Are you taking any medication for Osteoporosis?

☐ Fosamax ☐ Boniva ☐ Prolia ☐ Other: _____

Have you taken any Bisphosphonates, medicines for osteoporosis/bone disease in the past?

☐ Yes ☐ No **Signature**: _____

ALLERGIES TO MEDICINES:

ACKNOWLEDGEMENT OF HIPAA PRIVACY PRACTICES

PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY:

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protection health information to carry out treatment, payment activities, and healthcare operations. You also consent to having been provided with access to a copy of the company's Notice of Privacy Practices

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 regarding your protected health information and your patient rights under HIPAA. We encourage you to read it carefully and completely before signing this consent.
We reserve the right to change our privacy practices as describe 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 from the dental office, our website, or by contracting our Privacy Officer.

Contact: Dr. Ammar Mousa
Telephone: (352)748-1880
Email: wildwoodsmiles@gmail.com
Address: 590 S Main Street, Wildwood, FL 34785

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 the 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 your child if you revoke this consent.

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 health care operations.

If this consent is signed by a personal representative on behalf of the patient complete the following:

Patient's Name: _____

Relationship to Patient: _____

Personal Representative's Name: _____

_____ _____

Signature Date