WildSmiles
PEDIATRIC DENTISTRY

Online Form

101 4th Ave. E, Suite B
Crestview, FL 32539
850.384.9171

3201 East Olive Road
Pensacola, FL 32514
850.477.1722

DATE:____/____/____
info@wildsmilesdental.com

Patient Information

Child's Name: _____ Goes By: _____

Child's Date of Birth: _____/_____/_____ Age: _____ Sex: ( )M or ( )F SS#: _____-_____-_____

Child's Home Address: _____

City, State, Zip: _____

Primary Contact Phone Number: (_____)-_____-_____ School This Child Attends: _____ Grade: _____

Please tell us about the patient's interests and hobbies:

_____

Child Lives With: Both Parents Mother Father Splits Time with _____ Grandparent

Step-Parent _____ Foster Care Other _____

Person Filling Out Paperwork

Name: _____ Relationship to patient: _____

*If other than parent, Legal Guardianship paperwork is required before any treatment can be rendered.
Are you permitted by law (by right as a natural parent, legal guardian, legal adoption, or court order) to provide consent for the dental treatment of this child? **Yes** **No**

_____ _____

Signature Date

Parent/Guardian's Information

Mother Step-Mother Father Step-Father Guardian
Name: _____ DOB:___/___/____
SSN: _____/_____/_____
Address: ☐ Same as Child
_____
City, State, & Zip: _____
Cell Phone: _____
Employer Name: _____
Occupation: _____
Email: _____

Mother Step-Mother Father Step-Father Guardian
Name: _____ DOB:___/___/____
SSN: _____/_____/_____
Parents Live at Same Address ☐ Yes ☐ No
Address: _____
City, State, & Zip: _____
Cell Phone: _____
Employer Name: _____
Occupation: _____
Email: _____

Do you have other children who are already established patients with our practice? ☐ Yes ☐ No
If yes, name of patient(s): _____
DOB: _____/_____/_____

See Back Side

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Lauren Simon, DMD & Board-Certified Pediatric Dentist
Stu Bonnin, DMD & Board-Certified Pediatric Dentist
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Patient Name: _____
Date: _____

Patient Medical/Dental History

Primary Care Physician _____ Phone # _____ Date of last exam _____

Is this child taking Medicine now? No Yes

List any Medications: _____ _____ _____ _____

Treatment For: _____ _____ _____ _____

For office use only:
Notes: _____ _____ _____ _____

Has this child ever been hospitalized? No Yes Why? _____
Has this child ever been treated in the emergency room? No Yes Why? _____
Does this child have or has this child ever had any of the following conditions?

Yes	No	Allergies	Yes	No	Diabetes/Endocrine System	Yes	No	Liver Disease
Yes	No	Anemia	Yes	No	Down Syndrome	Yes	No	Mouth Breathing
Yes	No	Asthma	Yes	No	Drug Reactions	Yes	No	Pacifier Use
Yes	No	Autism	Yes	No	Fainting Spells	Yes	No	Pregnancy
Yes	No	Birth Defects: _____	Yes	No	Frequent Headache	Yes	No	Premature/Low Birth Weight
Yes	No	Bleeding Problem/Transfusion	Yes	No	Frequent Infections	Yes	No	Psychiatric/Emotional Problems
Yes	No	Breathing Problems	Yes	No	Heart condition/Murmur	Yes	No	Rheumatic Fever
Yes	No	Cancer Type: _____	Yes	No	Hearing Loss/Impairment	Yes	No	Sensory Concerns
Yes	No	Cerebral Palsy	Yes	No	History of Finger/Thumb Sucking	Yes	No	Seizures Type: _____
Yes	No	Cleft Lip and/or Palate	Yes	No	Hypertension	Yes	No	Sickle Cell Anemia
Yes	No	Cystic Fibrosis	Yes	No	Hyperactivity/ADD/ADHD	Yes	No	Sleep Apnea/Snoring
Yes	No	Delayed Speech Development	Yes	No	Kidney Disease	Yes	No	TB, HIV, Hepatitis Type-_____
Yes	No	Developmentally Delayed	Yes	No	Latex Sensitivity	Yes	No	Vision Problems

Other Medical Concerns: _____
What brings your child in today? (What is your main dental concern?) _____
_____
Has your child previously seen a dentist? No Yes: What dental pratice, name of dentist? _____
How often does the patient brush? _____ Floss? _____ By whom? _____
Does this patient have a special diet? No Yes: _____
What does this child drink on an average day? Cows Milk Juice Breastmilk Water Gatorade Soda
Energy Drinks Coffee Tea Favorite Drink _____

I certify that I have read and understand the above information is to the best of my knowledge and the above questions have been correctly answered. I understand that providing incorrect or incomplete information can be dangerous to the health of this patient. I will not hold Dr. Rachel Witcher or any staff responsible for any errors in ommison that I may have made during the completion of this form.

Signature _____ Date: _____

How Did You Hear About Us?

How did you hear about our office? (Check all that apply.)
Dr.'s Office Facebook Family/Friend Google Magazine Other _____ Promotional Offer

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Patient Name:_____
Date:_____

Dental Insurance Information

☐ No, I dont have dental Insurance
☐ Yes, I have dental insurance (please give card to front desk to scan or email electronic copy to info@wildsmilesdental.com

Is this dental insurance provided by your employer? ( ) No ( ) Yes: Name of Employer:_____

Insurance Company:_____ Group Number:_____

Policy Number:_____ Name of Policy Holder:_____

Date of Birth: ____/____/____ SS#: ____-_____-____

Insurance Company Address: _____ Insurance Phone Number: _____

Acknowledgement of Receipt of Notice of Privacy

I, _____ acknowledges receipt of a copy of the current effective Notice of Privacy Practices policy. A copy of this signed, dated acknowledgement shall be effective as the original.

_____ _____

Signature Date

Office Policy Form/Consent Practices

Please read and initial next to each paragraph.

_____ Initial
I understand that an initial and recall dental appointment can include a visual exam of the oral area, a radiographic (x-ray) exam, prophylaxis (cleaning), fluoride treatment, and Oral Hygiene Instruction (OHI) when necessary. I understand that digital photographs will be taken as part of my child's clinical record. I give permission to Dr. Rachel Witcher, Dr. Bonnin, and Dr. Lauren to perform these examinations and procedures on my child at the initial and each subsequent recall appointment. I understand that these services are Dr. Rachel Witcher's standard of care based on the American Academy of Pediatric Dentistry guidelines, and are not based on insurance benefits or coverage frequency.

_____ Initial
Please be advised that scheduling an appointment is your confirmation of the appointment. Not being contacted by the office is not an excusable reason for any missed appointments. As a courtesy to others who would like to be scheduled, there is a $25.00 now show/cancellation fee for missed or cancelled appointments without 24 hour notice.

_____ Initial
We are a specialty clinic and all fees are due at the time of service. Some services require to be prepaid in order to reserve an appointment time. As a courtesy, we will provide an insurance claim form to be mailed by the patient/guarantor.

_____ Initial
Be sure to arrive at your appointment on time. We respect our patients' time and make every effort to remain on schedule. If more than 10 minutes late to scheduled appointment, visit may need to be rescheduled. Dr. Rachel Witcher will not "rush" to "make up" time lost.

_____ Initial
Electronic Communication Consent: I agree that this practice may electronically communicate with me through the email address and phone numbers I have provided.

_____ Initial
We are a fee-for-service office. This means payment is due in full at the time of service. We file insurance as a courtesy.

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Patient Name: _____
Date: _____

Patient Authorization Form

I consent to the following people, whether legal guardian or not, to bring my child in for their dental appointment and give these people the ability to make dental/medical treatment decisions for my child:

1. I give the authorization to release medical information to Family Member(s), Guardian, and others.
2. I give authorization for consent for Family Member(s), Guardian, and others to accompany patients to dental/medical appointments.
3. I give authorization for Family Member(s), Guardian, and others to consent to dental/medical treatment.
4. If you do NOT want any other party to bring your child/children to their dental visits, please write "none" in the below blanks.

Name: _____ Relation to Patient: _____ Contact #: _____

Name: _____ Relation to Patient: _____ Contact #: _____

Name: _____ Relation to Patient: _____ Contact #: _____

Name: _____ Relation to Patient: _____ Contact #: _____

_____
Patient Name (Please Print)

_____
Legal Guardian Name (Please Print)

_____ _____
Legal Guardian Signature Date

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Patient Name: _____
Date: _____

Consent for Treatment

(Please include all patient names' below, including siblings to consent for treatment at our practice.)

Patient Name : _____

I, being the parent or guardian of the above minor patient(s), hereby do authorize and request the performance of dental services for the patient(s) and the use of whatever procedures the doctor may deem necessary during treatment.

I understand that Dr. Bonnin, Dr. Rachel, and Dr. Lauren, as well as, assistants as he may designate to treat the above-mentioned patient(s) will use restorative, oral surgery and patient management techniques that are reasonable, necessary and advisable.

I also authorize the administration of anesthetics or analgesics, which may be deemed advisable by Dr. Bonnin, Dr. Rachel, or Dr. Lauren.

I understand that the treatment plan to be presented, along with the fees outlined, could change depending upon the time elapsed since the initial examination and the extent of dental pathology. Furthermore, by signing this, I agree to be responsible for full payment of all charges for dental services performed on the above-named patient or patients.

I hereby authorize and consent to any treatment or procedure or the administration of necessary anesthetics which my child's dentist deems advisable in the diagnosis and/or treatment of this patient. By signing this medical authorization and consent, I understand that as a matter of law it shall be conclusively presumed:

A.) That the action of my dentist in obtaining this consent from me was in accordance with an accepted standard of medical-dental practice among members of the medical-dental profession with similar training and experience in this or similar medical communities; and from information provided me by my dentist, I under these circumstances, have at least a general understanding of the procedures, the medically accepted alternate procedures or treatments and the substantial risks and hazards inherent in the proposed treatment or procedures which are recognized among dentists in this of a similar community who perform similar treatments or procedures; or

B.) That I, considering all the surrounding circumstances, would have undergone such treatment or procedure had I been advised by my dentist as described in paragraph A above.

_____ _____

Signature of Authorized Person on Behalf of Patient Date

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Date: _____

Consent for Dental Photography and Social Media Form

PATIENT CONSENT

I, _____ _____
First name Last name

consent to dental images and / or video being made of me or my child / dependent.
I agree that duplicates may be made for the referring doctor.

I agree that the images may be:
(Please check below to show consent)

	Yes	No
... placed in my dental record for future treatment	☐	☐
... electronically emailed to my treating health professional	☐	☐
... used by dental health professionals for education and training	☐	☐
... used in paper or electronic dental health publications	☐	☐
... used in commercial broadcast	☐	☐
... used in marketing materials (Facebook/Website)	☐	☐

By signing below, I confirm that I understand this consent form.

_____ _____
Signature of Authorized person on behalf of patient Date