SERENITY VALLEY
Family Dentistry

We are happy to have you join our great family of patients and friends. Please complete this form so that we can provide the best care possible for you.

Thank you!

ABOUT YOUR CHILD

Name:_____ ☐ Female ☐ Male

Address: _____

City: _____ State:_____ Zip: _____

_____

Home phone: _____ Cell phone:_____

Birth date: _____/_____/_____ Grade: _____ Age: _____ Is this your child's first dental visit? ☐ Yes ☐ No

Who can we thank for referring you? _____

EMERGENCY INFORMATION

Person to contact: _____

Relationship:_____ Phone: _____

I give permission for Serenity Valley Family Dentistry to share my medical and account information with:

_____

DENTAL HISTORY

Do you have any concerns with your child's teeth, such as a chipped tooth, decayed tooth, gumboil, etc.?

☐ Yes ☐ No If Yes, please explain_____

How often do they brush? _____ How often do they floss? _____

Medical History

Is your child in good health? ☐ Yes ☐ No When was your child's last medical exam? Date _____/_____/_____

Has your child required hospitalization or had a serious illness? ☐ Yes ☐ No

If Yes, please explain: _____

Are your child's immunizations up-to-date? ☐ Yes ☐ No

Is your child sensitive/allergic to anything? ☐ Yes ☐ No

If Yes, please explain: _____

_____

Is your child presently taking any medications? ☐ Yes ☐ No

If Yes, please explain: _____

Please check any of he following that apply to your child:

☐ Anemia
☐ Asthma
☐ Attention disorder
☐ Breathing disorders
☐ Counseling
☐ Diabetes
☐ Epilepsy
☐ Hay fever
☐ Hearing impairment
☐ Heart murmur
☐ Mitral valve prolapse
☐ Rheumatic fever
☐ Visual impairment
☐ Other _____

The information I have given is true and accurate to the best of my knowledge.

3633 Lincoln Street, Suite C, Fargo, ND • (701) 373-0681

When a health care worker is exposed to my blood or body fluids through a needle stick, cut or splash to the eye or mouth, I agree to have my blood tested for blood-borne diseases to include Hepatitis B and C Virus and Human Immunodeficiency Virus (AIDS). Initial: _____

I, the undersigned certify that I (or my dependent) have insurance coverage with _____ and assign directly to the doctor, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the us of this signature on all insurance submissions.

I understand that I may be charged a 1.5% finance charge per month (18% annually) if my balance goes beyond 90 days. I also understand that I am responsible for all fees pertaining to my unpaid balance and/or missed appointments.

I give permission for my dentist and clinical team to take any necessary radiography, study models, and photographs to make a complete diagnosis of my dental needs. I also give permission for my dentist and dental team to use my photographs for in-office patient education.

I consent to the use and disclosure of my protected health information to obtain payment information in connection with my dental claims.

Signature _____ Date _____/_____/_____

Parent's Signature (If under 18) _____ Date _____/_____/_____
(I have read, agree to, and understand the statements listed above)

APPOINTMENT CANCELLATION POLICY
When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, we kindly request that you contact us by phone with advanced Notice of two business days. We understand that conflicts arise; however failing your appointment or canceling without adequate Notice more than once will result in a $50 charge and then discontinuation of services.
Initials:_____