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

APPOINTMENT POLICY

Thank you for choosing Serenity Valley Family Dentistry. We believe that it is our responsibility to use our best professional care, skill, and judgement in helping you achieve your dental health goals.

We reserve your scheduled appointment time just for you. As a courtesy to our team and other patients in the schedule, please arrive on time. Late arrivals will be worked into the schedule if time allows or reappoint to another day.

We will verify your insurance; however, verification is not a guarantee of payment. You are responsible for all charges not paid by insurance at your scheduled appointment. Any balance after 90 days will be sent to collections.

If you need to reschedule your appointment, we kindly request that you contact us by phone with advanced notice of 2 business days. We understand that situations can arise although failing your appointment or cancelling multiple times without notice will result in discontinuation of services at our office.

Our office will make every effort to confirm your appointment. If it goes unconfirmed 24 hours prior to the appointment, we reserve the right to take you out of the schedule due to no confirmation.

Signature _____ Date _____/_____/_____

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