Welcome to Smiles+Grins Kids Dental! We are pleased that you have chosen our practice as your child's dental home and we look forward to meeting you. I would like to remind you of test's first appointment with Dr. Liel Grinbaum for

Please fill out your NEW PATIENT FORMS prior to your appointment. You may find your NEW PATIENT FORMS attached to this email.

Dr. Liel Grinbaum is a Board-Certified Pediatric Dentist and has gone through extensive training to ensure your children's dental needs are fully taken care of. It is our commitment to provide you with the highest quality care and a great experience for both you and your children. We value your time so in order to keep you on schedule, we ask that you confirm your scheduled appointment or, if needed, provide us with adequate (48 hours) notice to reschedule.

Our patient's experiences begin in their home. Stories of bad experiences, fear or pain, will cloud their own experience and may lead to an unfavorable time at the dentist. Going to the dentist should be fun and exciting and we at Smiles+Grins, are dedicated to delivering the best possible experience.

The appointment begins with a fun and interactive introduction to the staff and Dr. Grinbaum. A full and detailed examination of the mouth will follow. Radiographs will be recommended depending on the patient's dental history or if Dr. Grinbaum feels they are necessary. If any x-rays were taken in the last 6 months, please e-mail us a copy to Info@smilesandgrins.com. We appreciate that you chose our office and look forward to meeting you at your first visit!

Please visit our website for more information: https://smilesandgrins.com/

Kind regards,

Sharis Perez

Treatment Coordinator

Child's Full Name: _____

Nickname: _____ Date of birth: ____/____/_____

Gender: ▢ M ▢ F How did you hear about our office: _____

Home Address: _____

Phone Number: _____

E-mail Address: _____

Name/address/phone of primary physician:

_____

Name/address/phone of medical specialists:

_____

Is your child being treated by a physician at this time? Reason

_____ ▢ YES or ▢ NO

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements?

…….. ▢ YES or ▢ NO

List name, dose, frequency & date started:

_____

Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? ..... ▢ YES or ▢ NO

List date & describe:

_____

Has your child ever had a reaction to or problem with an anesthetic? Describe

_____ ▢ YES or ▢ NO

Is your child allergic to latex or anything else such as metals, acrylic, or dye? List

_____ ▢ YES or ▢ NO

Is your child up to date on immunizations against childhood diseases?

..... ▢ YES or ▢ NO

Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions …… ▢ YES ▢ NO

Sinusitis, chronic adenoid/tonsil infections…….. ▢ YES ▢ NO

Sleep apnea/snoring, mouth breathing, or excessive gagging ……. ▢ YES ▢ NO

Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease …….. ▢ YES ▢ NO

Asthma, reactive airway disease, wheezing, or breathing problems... ▢ YES ▢ NO

Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems …….. ▢ YES ▢ NO

Rash/hives, eczema, or skin problems …… ▢ YES ▢ NO

Developmental disorders, learning problems/delays, or intellectual disability …….. ▢ YES ▢ NO

Cerebral palsy, brain injury, epilepsy, or convulsions/seizures ..... ▢ YES ▢ NO

Autism/autism spectrum disorder …….. ▢ YES ▢ NO

Behavioral, emotional, communication, or psychiatric problems/treatment …….. ▢ YES ▢ NO

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of those conditions applies to your child.

Please list all allergies your child has:

_____

_____

_____

Please list any other medical concerns for your child:

_____

_____

_____

Please check all sources of fluoride your child receives:

▢ Drinking water ▢ Toothpaste ▢ Over-the-counter rinse ▢ Prescription rinse/gel ▢ Prescription drops/tablets/vitamins

▢ Fluoride treatment in the dental office ▢ Fluoride varnish by pediatrician/other practitioner ▢ Other: _____

Does your child regularly eat 3 meals each day? ▢ YES ▢ NO

Is your child on a special or restricted diet? ▢ YES ▢ NO

➤ If YES, describe: _____

Does your child have a diet high in sugars or starches? ▢ YES ▢ NO ➤If YES, describe: _____

Do you have any concerns regarding your child's weight? ▢ YES ▢ NO ➤If YES, describe: _____

How frequently does your child have the following?

Candy or other sweets: ▢ Rarely ▢ 1-2 times/day ▢ 3 or more times/day.

Product: _____

Chewing gum: ▢ Rarely ▢ 1-2 times/day ▢ 3 or more times/day.

Type: _____

Snacks between meals: ▢ Rarely ▢ 1-2 times/day ▢ 3 or more times/day.

Usual snack: _____

Soft drinks*: ▢ Rarely ▢ 1-2 times/day ▢ 3 or more times/day. Product _____

(* such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)

Please note other significant dietary habits:

_____

Does your child participate in any sports or similar activities? ▢ YES ▢ NO

➤ If YES, list: _____

➤ If YES, type of mouthguard: _____

➤ If YES: Date of first visit: _____ Date of last visit: _____ Reason for last visit: _____

Were x-rays taken of the teeth or jaws? ▢ YES ▢ NO

Date of most recent dental x-rays: _____

Has your child ever had orthodontic treatment (braces, spacers, or other appliances)?
▢ YES ▢NO

➤ If YES, when? _____

Has your child ever had a difficult dental appointment? ▢ YES ▢ NO

➤ If YES, describe: _____

How do you expect your child will respond to dental treatment? ▢ Very well ▢ Fairly well ▢ Somewhat poorly ▢ Very poorly

Is there anything else we should know before treating your child? ▢ YES ▢ NO

➤ If yes, describe:

_____

_____

Do you have any concerns regarding your child's oral health? Please explain:

_____

Does your child have a history of any of the following? For each YES response, please describe:

Mouth sores or fever blisters? ▢ *YES* ▢ *NO*

_____

Bad breath? ▢ YES ▢ NO

_____

Bleeding gums? ▢ YES ▢ NO

_____

Cavities/decayed teeth? ▢ YES ▢ NO

_____

Toothache? ▢ YES ▢ NO

_____

Injury to teeth, mouth, or jaws? ▢ YES ▢ NO

_____

Clinching/grinding his/her teeth? ▢ YES ▢ NO

_____

Jaw joint problems (popping, etc.)? ▢ YES ▢ NO

_____

Sucking habit after one year of age ▢ YES ▢ NO

➤ If yes to sucking habit, which: ▢ Finger ▢ Thumb ▢
Pacifier ▢ Other For how long? _____

Is there anything else we should know before treating your child? ▢ YES ▢ NO

➤ If yes, describe:
_____
_____

Thank you for taking the time to answer these questions about your child. Your participation ensures that your child will get the best dental care based on their unique needs.

Signature of parent/guardian: _____

Relationship to child: _____ Date: _____

Signature of staff member reviewing history: _____

Financial Policy and Agreement

Here at smiles + grins, we offer a few payment options to our patients

1) Dental Insurance

Name of Primary Dental Insurance Co: _____

Group #: _____

Date of Birth of policy holder: ____/____/____

SSN of policy holder: ____-_____-____

Employer: _____

Name of Secondary Dental Insurance Co: _____

Group #: _____

Date of Birth of policy holder: ____/____/____

SSN of policy holder: ____ - _____ - ____

Employer: _____

As a courtesy to you, we will be happy to submit your claim to your

insurance company. This service will help you maximize your dental benefits. The insurance relationship constitutes an agreement between the carrier and the patient. As such, we cannot make a guarantee of estimated coverage or payment. However, please know that we will do everything possible to see that you receive the full benefits of your policy.

You will be responsible for all dental charges that your insurance company has not paid, for whatever reason, within a 45-day period from when treatment began. You will be expected to pay the total amount due. I am aware insurance may downgrade my coverage and may not pay for all services in full and it will be my responsibility to satisfy any balances on my account. insurance is only an estimate not a guarantee of coverage. I agree to pay for all services that are my responsibility.

X_____(sign here)

X_____(initial)

2) Self Pay

We accept Cash, Checks, Credit Cards (MasterCard, Visa, Discover, American Express).

Patients who chose to self-pay will be provided with the cost of each procedure, based off our office fee schedule. All payments are due at the time of service.

Person responsible for payment: _____

Relation to patient: _____

I understand that treatment will not be done until payment is made.