Annual Medical History Update

Patient's Name: ____________________________ Phone:______________

Date:___________ Street

Address:____

City:__________________ State:_________ Zip:__________

Are there any changes in the patient's medical history since the last visit?

◯Yes (please list): ◯No

Has your child been hospitalized since their last visit?

◯Yes (please list): ◯No

Are there any changes in your child's medications/allergies?

◯Yes (please list): ◯No

Has your child experienced any tooth pain/injury to the mouth since their last visit?

◯Yes (please list): ◯No

Any changes in patient information (insurance/phone/email/address)?

◯Yes (please list): ◯No

Please list any additional information or concerns:

Parent/legal guardian name: ______________________________________

Parent/legal guardian signature:____________________________________

Date:________________

As the dental professionals of Bright Smiles 4 Kids & The Dental Spa Group, we consider it of utmost importance to help protect the health of our patients' teeth, gums, implants, and restorations as well as overall health. Detection of disease and diagnosis begin with a comprehensive dental exam, an up-to-date medical and dental history, up-to-date X-Ray's, and full-mouth periodontal probing that includes a new focus on inflammation identification. Our providers adhere to this Standard of Care and in order to do so they provide treatment based on patient needs NOT insurance coverage. "One size does NOT fit all" when it comes to establishing X-ray schedules, hygiene schedules, etc. The providers take into account the patient's oral health condition, age, risk for disease and any signs and symptoms of oral disease that the patient might be experiencing.

It is your responsibility as the insured, to understand your individual plan and any services and frequency limitations. As a courtesy we do check eligibility of the plan and upon request we can check treatment frequency limitations. Our mission at Bright Smiles 4 Kids is to deliver premium dental care to the Main Line and beyond, serving all ages with a focus on enhancing health and well-being. We are dedicated to providing exceptional, patient-focused services that significantly improve life quality through advanced care and technology.

I understand that it is my responsibility to know my insurance coverage, I also understand that I can, at any time, ask for and receive estimates on X-ray's and any treatment.

X____

Self/Parent/ Legal Guardian

CREDIT CARD ON FILE AGREEMENT

The Dental Spa and Bright Smiles 4 Kids have implemented a new credit card policy. Like many other medical or dental offices, we have adopted a similar policy. We kindly request a credit card from our patients' guardian/guarantor, which may be used later to pay any balance that may be due on your bill. Co-pays are still due at the time of service. At registration and/or check-in, your credit card information will be obtained and kept securely until your insurance(s) have paid their portion and notifies us of the balance due, if any.

The information will be held securely until your insurance has paid their portion of the claim and notified us of any additional amount owed by the patient. At that time, we will notify you that your outstanding balance will be charged to your credit card. You may call our office if you have a question about your balance. We will send you a receipt for the charge. This "Card-on-File" program simplifies payment for you and eases the administrative burden on your provider's office. It reduces paperwork and ultimately helps lower the cost of healthcare. If you have any questions about the card-on-file payment method, please do not hesitate to let us know: 610-664-7244

By signing below, I authorize The Dental Spa and/or Bright Smiles 4 Kids to keep my signature and my credit card information securely on-file in my account. I authorize them to charge my credit card for any outstanding balances when due.

Visa ☐ MasterCard ☐ Discover ☐ American Express ☐

Name on Card (Print): ____

Cardholder Relationship to Patient: _____________________________________

Credit Card Number: ____________________ Exp. Date: ___/____

Please fill out information below for any person(s) you authorize this credit card for:

Patient Full Name (Print): _____________________________ DOB: ___/___/_____

Patient Full Name (Print): _____________________________ DOB: ___/___/_____

Patient Full Name (Print): ______________________________DOB: ___/___/_____

Credit Card Holder's Signature: _________________________ Date: ______________