MAGIC SMILES
FAMILY DENTISTRY FOR ALL AGES

SO THAT WE MAY PROCESS YOUR ACCOUNT AND/OR INSURANCE CORRECTLY, PLEASE COMPLETE THIS PATIENT ACCOUNT REGISTRATION FORM.

WHO IS RESPONSIBLE FOR THIS ACCOUNT? Circle one: MR MRS MS MISS DR **NAME:**

ADDRESS:

CITY, STATE: BIRTH DATE: / / SEX: M F

ZIP CODE: SOCIAL SECURITY NUMBER:

HOME PHONE: **EMPLOYER NAME:**

WORK PHONE" EMERGENCY CONTACT:

CELL #: EMERGENCY PHONE:

EMAIL: @

DENTAL INSURANCE PRIMARY COVERAGE

EMPLOYEE NAME;

ADDRESS:

CITY, STATE:

ZIP CODE:

HOME PHONE:

WORK PHONE:

BIRTH DATE: / / SEX: M F

SOCIAL SECURITY NO:

EMPLOYER:

INSURANCE NAME:

INS. ADDRESS:

GROUP # OR LOCAL #:

SUBSCRIBER #:

DENTAL INSURANCE SECONDARY COVERAGE

EMPLOYEE NAME:

ADDRESS:

CITY, STATE:

ZIP CODE:

HOME PHONE:

WORK PHONE:

BIRTHDATE: / / SEX: M F

SOCIAL SECURITY NO:

EMPLOYER:

INSURANCE NAME:

INS. ADDRESS:

GROUP # OR LOCAL #:

SUBSCRIBER #:

MEDICAL ISURANCE PRIMARY COVERAGE

INSURANCE NAME:

INS. ADDRESS:

GROUP #:

SUBSCRIBER #:

MEDICAL INSURANCE SECONDARY COVERAGE

INSURANCE NAME:

INS. ADDRESS:

GROUP #:

SUBSCRIBER #:

HOW DID HEAR ABOUT US? NEWPAPER PROVIDER FRIEND RELATIVE OTHER

Your insurance policy is a contract between you and your insurance company, you are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates. Payment is due at the time of service. We accept cash, checks and most major credit cards.

I authorize release of any information required in the course of examination and/or treatment. I permit payment of insurance benefits directly to the dentist for services rendered. I recognize and accept responsibility for payment of services not covered by insurance benefits.

Patient or Parent/Guardian Signature_____ Date____/____/_____

Phoenix
1701 E Thomas Road, Ste 204
Phoenix AZ 85016 -- 602-253-6600

Mesa
1457 W Southern Ave, #18
Mesa, AZ 85202 -- 480-610-2300

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HEALTH HISORY

Patient Name_____ DOB: ____/____/____ Today's Date ____/____/_____

Responsible Party's Name: _____ Patient's Sex Male ☐ Female ☐

1. Are you being treated by a physisican at this time? Yes ☐ No ☐

   Physicians's Name: _____ Physician's Phone Number: _____

   When was your last visit to this physician? Date: / /

2. Have you ever been a patient in a hospital Yes ☐ No ☐

3. Have you ever had any major illness or surgery? Yes ☐ No ☐

   If Yes, please specify: _____

4. Do you have any allergies to any medications or substance (eg: medication, latex) Yes ☐ No ☐

   If Yes, please specify: _____

5. Are you taking any medicaitons or stubstance at this time? Yes ☐ No ☐

   If Yes, please specify: _____

6. Do you have any problems with local anesthetics, antiboiotics or any medication? Yes ☐ No ☐

   If Yes, please specify: _____

7. Are you pregant or susupect that you might be pregnant? Yes ☐ No ☐

8. Do you take birth control medication? Yes ☐ No ☐

9. Do you smoke, chew, use snuff or any other form of tobacco? Yes ☐ No ☐

10. Do you have any pins or screws surgically implanted? Yes ☐ No ☐

11. Have you ever had treatment or medical consultation for any of the following?

☐ Blood/Circulatory System	☐ Eyes	☐ Liver	☐ Nose
☐ Bones	☐ Ears	☐ Lungs	☐ Skin
☐ Gastrointestinal/Stomach	☐ Heart	☐ Muscles	☐ Throat
☐ Endocrine Glands	☐ Kidney	☐ Nervous System	☐ Tonsils/Adenoids

☐ I have not had treatment for any of the above

12. Have you ever been diagnosed with any of the following conditions?

☐ ADD/ADHD	☐ Brain Injury	☐ Heart Disease	☐ Pneumonia
☐ Allergy	☐ Cancer	☐ Heart Murmur	☐ Rheumatic Fever
☐ Anemia/ Trait	☐ Cerebral Palsy	☐ Hemophilia	☐ Sickle Cell
☐ Arthritis	☐ Convulsions/Seizure	☐ Hepatitis	☐ Snoring
☐ Artifical Heart Valve/Implant	☐ Diabetes	☐ High Blood Pressure	☐ Speech Problems
☐ Artificial Joints/Prosthesis	☐ Emotional Issues	☐ HIV/AIDS	☐ Spina Bifida
☐ Asthma	☐ Epilepsy	☐ Latex Allergy	☐ Tuberculosis
☐ Autism	☐ Eye Problems	☐ Learning Disability	
☐ Behavioral Problems	☐ Fainting	☐ Leukemia	
☐ Bleeding Problems	☐ Hearing Loss	☐ Sleep Apnea	

13. Is there anything else we should know about your health that we have not covere Yes ☐ No ☐

   If Yes, please specify: _____

To the best of my knowledge the questonis on this form have been accurately answered. I understand that providing incorrect information could be dangerous to my health.

Patient/Guardian Signature: _____

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PEDIATRIC DENTAL TREATMENT CONSENT FORM

As health professionals, it is necessary that we obtain your consent/oral treatment on your child.

_____ _____

_____ _____

Please read this form carefully and ask any questions that may not be clear or you may not understand.

I_____ Authorize Doctor Associated with Magic Smiles Dental
Parent or Guardian Name
Care and His/Her assistants to treat my child for the following dental or oral surgery procedures. Including the use of oral anesthesia, nitrous oxide, and sedatives or radiographs that may be necessary.

In General terms those procedures include.

____ A. Dental cleaning, fluoride application and radiographs as necessary.

____ B. Application of sealants to dental fissures.

____ C. Restoration of broken teeth or fillings.

____ D. Treatment of infected teeth or gums.

____ E. Extractions of one or more teeth

My Child's treatment, alternative methods of treatment, as well as advantages and disadvantages of each have been explained to me. I have been advised that although the best results are expected, there is no way within reason of anticipating complications. Therefore it is not possible to guarantee the results or cure of the treatment.
Although the occurrence is extremely remote, it is known that some risks are associated with dental procedures.

We are required to mention the following: numbness, infection, damage to central nervous system, reduction or loss of function of internal organs and limbs, as well as disfiguring scars. I understand that certain complications may be fatal or require future medical intervention.

_____ _____ _____
Parent or Guardian Signature Date Witness

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MAGIC SMILES
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MAGIC SMILES DENTAL CARE INFORMED CONSENT FOR PATIENT MANAGEMENT TECHNIQUES

Please read carefully and ask about anything on this form. We will be happy to explain it further.

It is our intent that our dental care delivery be the best quality available. Providing high quality dental care to children can be difficult due to their behavior. **This is why we ask that you allow your child to come into their appointment room alone. We find one on one communication to be most effective. Please give our policy a chance as it is in the best interest of your child.**

Every effort will be made to obtain your child's cooperation through warmth, charm, humor and understanding. When these fail there is several behavior management techniques used to eliminate or minimize disruptive behavior. These are all routinely used and accepted by the American Academy of Pediatric Dentistry, and are described below.

1. **Tell-show-do:** The dentist or assistant explains to the child what is to be done by demonstrating on a model or on the child's finger. Then the procedure is done on the patient's tooth. Praise is used to reinforce cooperative behavior.
2. **Positive reinforcement:** This technique rewards the child who displays any desirable behavior. Rewards include complements, praise, and a pat on the arm or a prize.
3. **Voice Control:** The attention of a disruptive child is gained by changing the tone or increasing the volume of the practitioner's voice.
4. **Mouth Props:** A rubber device is gently placed in the child's mouth to prevent either intentional or unintentional closure on the dentist's fingers or drill.
5. **Physical restraints by dentist/assistant:** The child is held so they cannot grab a moving drill or a sharp object. They are not able to grab the practitioner's hand while delicate work is being performed. This is for the safety of the child and to facilitate treatment.
6. **Laughing Gas:** Nitrous oxide (laughing gas) is administered to calm and soothe the patient prior to a stressful procedure. Nitrous oxide is a very safe medication that rarely causes nausea. The patient is <u>always</u> awake and <u>never</u> loses consciousness.
7. **Pedi-Wrap:** This is a protective immobilization device to limit the patient's disruptive movements and to prevent injury. It is used only as a last resort when treatment can be accomplished no other way.

The listed pediatric dentistry behavior management techniques have been explained to me. I understand their use, and the risks/benefits/alternatives available. I have had all my questions answered and I realize I can always seek further information or revoke permission for any of these techniques. This consent will remain in full force unless withdrawn in writing by the person who has signed on behalf of this minor patient.

_____ _____

Parent/Guardian Signature Date

Phoenix
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Phoenix AZ 85016
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MAGIC SMILES
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CONSENT FOR LOCAL ANESTHETIC INJECTIONS

I, (print name) _____, hereby authorize

Doctor Associated with Magic Smiles Dental to perform a local anesthetic injection(s).

I understand, and it has been explained to me, that there are some risks in the administration of local anesthetics. Most risks are related to the position of the nerves under the tissue at the site of the injection which cannot be determined prior to the administration of the anesthetic agent. Although the risks seldom occur they might include loss of, or disturbed sensation of the tongue and lip on the side of the injection. If this occurs it is often temporary, and normal sensation usually returns in several days. However, in very rare cases the loss of sensation may extend for a longer period and may become permanent. In addition, injecting a foreign substance into the body such as an anesthetic agent, may result in an allergic reaction. Allergic reactions to these agents are rare, but may take place.

I further understand that individual reactions to treatment cannot be predicted, and that if I experience any unanticipated reactions following the injections(s), I agree to report them to the office as soon as possible.

I have been told that the success of any dental treatment depends upon my cooperation in keeping scheduled appointments, following home care instructions, including oral hygiene and dietary instructions, taking prescribed medication and reporting to the office any changes in my health status.

I acknowledge that no guarantees or assurances have been given by anyone as to the results that may be obtained.

I have discussed all the above with the doctor, and have had all of my questions answered.

_____ _____

Patient's Signature | If a Minor, Signature of Parent or Guardian

_____ _____

Witness Signature | Date

Phoenix
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Phoenix AZ 85016
602-253-6600

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NITROUS OXIDE INFORMED CONSENT

I hereby give permission for Doctor associated with Magic Smiles Dental Care and staff to perform nitrous oxide sedation.

I understand that the administration of medication and the performance of conscious sedation with nitrous oxide carried certain common hazards, risks, and potential unpleasant side effects which are infrequent, but none the less, may occur. They include but are not limited to the following:

1. Excessive Perspiration: Sweating may occur during the procedure and you may become Somewhat flushed during administration of nitrous oxide.
2. Expectoration: Removal of secretions may be difficult but can be controlled by use of Suction tip.
3. Behavior Problems: Some patients will talk excessively. You may become difficult to treat because you are so talkative, or experience vivid dreams associated with physical movement of the body.
4. Shivering: Although not common, shivering can be quite uncomfortable. Shivering usually develops at the end of the sedative procedure when the nitrous oxide has been terminated.
5. Nausea and Vomiting: This is the most frequent of the side effects of nitrous oxide sedation but its frequency is still quite low. It is important to tell the doctor, hygienist, or assistant that you are experiencing some discomfort. The level of nitrous oxide can be adjusted to eliminate this side effect.
6. Driving a Motor Vehicle: You may not feel capable of driving after nitrous oxide. If this occurs, we will keep you until you feel better or have you call a friend or cab to insure your safety.

I have been advised of alternative treatment, the benefits and risks which include but are not limited to:

Fear and anxiety of the dental experience and/or avoidance of future dental appointments. These fears and anxiety, if not diminished by the use of nitrous oxide sedation, may precipitate other medical problems including fainting, palpitation and other heart-related disorders.

The benefits one can expect from nitrous oxide sedation include:

Help with anxiety and pain, gagging and medically compromised individual.

I hereby certify that I understand this authorization and the reasons for the above named sedative procedure and associated risks, I am aware that the practice of dentistry is not an exact science. I acknowledge that every effort will be made in my behalf for a positive outcome from sedation, but no guarantees have been made to the result of the procedure authorized above.

_____ _____

Signature Date

Phoenix
1701 E Thomas Road, Ste 204
Phoenix AZ 85016
602-253-6600

Mesa
1457 W Southern Ave, #18
Mesa, AZ 85202
480-610-2300

MAGIC SMILES
FAMILY DENTISTRY FOR ALL AGES

Magic Smiles Dental Care
1701 E Thomas Road, Suite 204 Phoenix AZ 85016
Phone 602-253-6600 Fax 602-279-0821

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been given the opportunity to receive a copy of **Magic Smiles Dental Care**'s Notice of Privacy Practices, which has an effective date of 10/01/2014 and which describes how my health information may be used and disclosed.

I understand that you have the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices:

_____ _____
Signature of Patient or Patient's Representative Date

_____
Print Name

_____
Relationship to Patient (If not signed by the Patient)