Katina Beverly, D.D.S., LLC
TWINkling Smiles

1203 North 5th St.
Monroe, LA 71201

Patient's Name_____ **Nickname**_____

Age_____ Birthdate_____ Sex**:** M / F **Weight**_____ Height_____

Patients SS # (required):_____**Referred by: _____**

CHILD'S MEDICAL HISTORY:

Has your child ever had any of the following:	**YES**	**NO**
1. Heart Murmur	_____	_____
2. Asthma	_____	_____
3. Diabetes	_____	_____
4. Seizures	_____	_____
5. Abnormal Bleeding/ Bleeding Disorder	_____	_____
6. Attention Deficit Disorder (ADD/ADHD)	_____	_____
7. Tuberculosis	_____	_____
8. Handicaps/Disabilities	_____	_____
9. Congenital Heart Defect	_____	_____
10. Rheumatic Fever	_____	_____
11. HIV/AIDS	_____	_____
12. Cancer	_____	_____
13. Hepatitis	_____	_____
14. Autistic	_____	_____
15. Allergies to Medication (i.e. Penicillin) List: _____	_____	_____

Please list any current medications your child is taking: _____

Has your child ever been hospitalized? Y / N
Explain: _____

Please describe any health problems not listed above: _____
_____

Child's Physician: _________

I hereby state all medical information given is true to the best of my knowledge.
Please Sign: _____

Medical History Update:
_____
_____

Patient's Name_____ Birth date: _____

Home Address_____

City_____ Zip_____

Home Phone_____ Cell Phone_____

If you are not the parent, please state your relationship to child: _____

Mother's Name_____ Birth date: _____
(Guardian)

Social Security #:_____ Driver's License#:_____

Father's Name: _____ Birth date: _____
(Guardian)

Social Security #:_____ Driver's License#:_____

Married_____ Separated_____ Single_____ Widowed_____ Divorced_____

Place of Employment:

Father_____ Phone _____

Mother _____ Phone_____

Person responsible for this account:
_____

Payment of Professional Fees: Please check one
Cash _____ Credit Card_____ (We do not accept checks) Insurance_____

Insurance Co _____ Policy #_____

What particular dental problem does your child have which you think needs my attention?
_____

Emergency Contact _____ Relationship_____
Address_____ Phone_____

INSURANCE AUTHORIZATION, ASSIGNMENT AND CONSENT FOR TREATMENT
I hereby authorize TWINkling Smiles to furnish information to insurance carriers concerning my dental treatment and I hereby assign to the dentist all payments for dental services rendered to my dependents. I understand that I am responsible for any amount not covered by insurance. I hereby authorize Dr Katina Beverly to render dental treatment to my child as needed, including: Radiographs (X-Rays), Local Anesthesia, Nitrous oxide, **EXTRACTIONS,** Fillings, Crowns, Root Canals, Spacers, etc.
Please sign_____ Date_____

Medical Release Authorization
I wish to appoint someone to act in my place in my absence and to give such authorization. This authorization is intended to give _____ and or _____ the right to give consent to authorize Total Dental Care.

Please sign_____ Date_____

Acknowledgement of Receipt Of Privacy Policy

I, _____ have received a copy of
(**Name of Patient being seen by Dr**)

Katina Beverly, D.D.S., LLC- Twinkling Smiles - Notice of Privacy Practices.

Signature of Parent/Guardian: _____

Staff Will Fill This Section If Patient's Signature Not Obtained

Our office made a good faith effort to obtain **Acknowledgement of Receipt** of our Notice of Privacy Practices, but it could not be obtained for the following reason
_____ Patient refused to sign
_____ Emergency situation kept us from obtaining the patient's signature.
_____ Language barriers kept us from obtaining the patient's signature.
_____ Other _____

No Show Policy

Thank you for choosing Dr. Katina Beverly to be your dental provider! We strive to give each of our patients the best in dental care. Our patient's dental concerns are very important to us and we try to accommodate our patients with appointment times that are convenient to them. Due to an increased number of patients who do not show up for their appointments, we are implementing a No Show Policy. If you "no show" two (2) appointments we will no longer be able to see you in our office. A "no show" is defined as canceling your appointment less than four hours before your appointment or not showing up at all. Unfortunately, this is necessary in order to give our patients the best dental care. Our goal is to keep our appointments available for patients who need medical attention. We ask that you give our office a 24 hour notification if you do need to cancel your appointment. Again, thank you for choosing Dr. Beverly as your dentist!

I do hereby acknowledge that I have read and do understand the above policy regarding NO SHOWS:

Child'sName:_____
Parent's Name (Printed) : _____
Parent's Signature: _____