

thank you for selecting us.

Patient ID # _____

Today's Date _____

We strive to make each of your child's visits pleasant and comfortable. Please fill out this form completely in ink.

Your Child

Child's Name _____ Sex _____ Age _____

Nickname _____ SS#/SIN _____ Birthdate _____

School _____ Grade _____

Child's Home Address _____

City _____ State/Prov. _____ Zip/P.C. _____ Phone _____

Responsible Party

Name _____ Relationship _____

Address _____ Email _____

City _____ State/Prov. _____ Zip/P.C. _____

Home Phone _____ Cell Phone _____ Work Phone _____

SS#/SIN _____ DL # _____

Who is Responsible for Making Appointments? _____

Parent or Guardian Information

Mother

Stepmother

Guardian

Name _____ Email _____

Home Phone _____ Cell Phone _____ Work Phone _____

Employer _____ Occupation _____

SS#/SIN _____ DL # _____

Marital Status Single Married Separated Divorced Widowed

Parent or Guardian Information

Father

Stepfather

Guardian

Name _____ Email _____

Home Phone _____ Cell Phone _____ Work _____

Employer _____ Occupation _____

SS#/SIN _____ DL # _____

Marital Status Single Married Separated Divorced Widowed

Primary Insurance

Insured's Name _____ Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____ Occupation _____

Insurance Co. _____ Group # _____ Employee # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Deductible _____ Copay _____ Amount already used _____ Max. annual benefit _____

Additional Insurance

Insured's Name _____ Relationship _____

Birthdate _____ SS#/SIN _____

Employer _____ Date Employed _____ Occupation _____

Insurance Co. _____ Group # _____ Employee # _____

Ins. Co. Address _____ City _____ State/Prov. _____ Zip/P.C. _____

Deductible _____ Copay _____ Amount already used _____ Max. annual benefit _____

Over Please



Dental/Medical Health History (Confidential)

Your child's overall health as well as any medications which your child takes could have an important interrelationship with the dental care your child receives. Please answer each of the following questions completely.

Patient ID # _____

How often does your child brush? _____

How often does your child floss? _____

Is your child's water fluoridated? Yes No

Does your child take fluoride supplements? Yes No

Does your child:

Suck Thumb/Finger Yes No

Suck/Bite Lip Yes No

Bite/Chew Nails Yes No

Chew Hard Objects (pencils, etc.) Yes No

Grind Teeth Yes No

Clench Jaws Yes No

Date of Last Dental Visit _____

Previous Dentist _____

Address _____

Has your child had difficulty with previous dental visits? Yes No

Has your child ever taken Fen-Phen/Redux? Yes No

Has your child ever had any of the following:

Asthma Yes No

Handicaps/Disabilities Yes No

Cancer Yes No

Tuberculosis Yes No

Hepatitis Yes No

Diabetes Yes No

HIV/AIDS Yes No

Rheumatic Fever Yes No

Hemophilia Yes No

Congenital Heart Defect Yes No

Abnormal Bleeding Yes No

Heart Murmur Yes No

Stomach, Liver or Kidney Problems Yes No

Convulsions/Epilepsy Yes No

A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks) Yes No

Child's Physician _____ Phone # _____

Address _____

Previous Hospitalizations/Surgeries/Serious Illnesses _____ When? _____

Is your child currently taking any medications? Yes No (if yes, please list) _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocain, etc.)? Yes No

(if yes, please describe) _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? _____

Please explain any medical problems that your child has: _____

Financial Arrangements

For your convenience, we offer the following methods of payment. Please check the option you prefer. Payment in full at each appointment.

Cash Personal Check Credit Card VISA MasterCard I wish to discuss the office's payment policy.

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Signature of Patient (or Parent/Guardian if minor) _____ Date _____

Dentist's Review: _____

Signature of Dentist _____ Date _____

Kids Dental Clinic Office Policy

ALL DENTAL APPOINTMENTS ARE CONSIDERED RESERVED AND CONFIRMED APPOINTMENTS

We will give you a courtesy call 2-3 days prior to your appointment to remind you of the date and time of your appointment.

However, it is your responsibility to be here as scheduled. If you cannot make your appointment, we require no less than 24 hours notice. There is a broken appointment charge of \$25.00 per scheduled half hour for all broken appointment without a full 24 hours notice.

If you are running late, you must call as soon as possible so that we can determine if there is enough time available or if the appointment will need to be rescheduled.

This policy is necessary to keep our schedules running smoothly so that patients will be able to be seen as scheduled.

I authorize treatment of and agree to pay all fees and charges for such treatment. I agree to pay for all charges for me and all members of my family promptly upon presentation there of. I hereby authorize the release of and presentation to my insurance company for benefits assigned to this office where applicable and that this office assumes no responsibility for the collection of any proceeds of insurance.

I hereby authorize the release of any pertinent information to my insurance company and any other doctors involved in my case. If my account is assigned to a collection agency, I agree to pay the 35% collections agency fee, all court costs, and attorney fees. I understand that all accounts with an unpaid balance over 30 days will be assessed a 1.5% late charge per month. There is a \$35.00 returned check fee for all returned checks.

I understand that my refusal to completely fill out patient information forms including providing my social security number (required for insurance verification purposes) may result in refusal to treat and or the insistence of payment by guaranteed funds, i.e. cash.

I have read, understand, and agree to the above terms.

Name of Parent/Guardian (Please print) _____ Date _____
Signature of Parent/Guardian _____ Date _____

HIPAA
(Health Insurance & Accountability Act of 1996)

Patient Acknowledgement

Patient name

Thank you for taking the time to review how we are carefully using your health information. If you have any questions, we want to hear from you. If you do not, we would appreciate very much your acknowledging your receipt of our policy by signing and returning this card.

Patient/Guardian Signature _____

You reserve to right request your information not to be released to

IE: Do not bill my insurance
Do not release my information to my spouse

Please circle one

- Please provide me with a copy
- I do not require a copy

Kids Dental Clinic
HIPAA Privacy Officer