Patient Information First Last

Patient's Name _____ Preferred Name _____ Sex _____

Mailing Address _____

(Street) (City, State) (Zip)

Date of Birth: _____ Age: _____ Weight: _____

Child lives with: Both Parents ____ Mother ____ Father ____ Other____

Patient's Physician/Pediatrician Name: _____ Last Physical: _____

Names of Sibling (s):

Child's Name: _____ DOB: _____ Age: _____

Child's Name: _____ DOB: _____ Age: _____

Email Address: _____ How did you hear about us: _____

Responsible Party Information

Mother

Name: _____ Marital Status: _____

Address if different from above: _____

Social Security No. _____ DOB: _____ Employer: _____

Phone: Home _____ Work _____ Cell _____

Father

Name: _____ Marital Status: _____

Address if different from above: _____

Social Security No. _____ DOB: _____ Employer: _____

Phone: Home _____ Work _____ Cell _____

Dental Insurance Information

Primary Insured's Name: _____ Insured's SSN: _____ DOB: _____

Primary Insured's Employer: _____ Insurance Company: _____

Insurance Company Address _____ Phone Number: _____

Subscriber Number: _____ Group Number: _____

I understand that I am financially responsible for all charges whether or not paid by my child's insurance. I assign directly to Dentistry For Kids all insurance benefits, if any, otherwise payable to me for services rendered. _____

(Please Sign/Date)

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PEDIATRIC DENTISTRY & ORTHODONTICS
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Patient's Name: _____

Medical History

Y N	Y N	Y N	Y N
☐☐ AIDS/HIV	☐☐ Ear disorders/Hearing loss	☐☐ Measles/Mumps	☐☐ Other
☐☐ Anemia	☐☐ Epilepsy/Seizures	☐☐ Muscle Disorder	
☐☐ Asthma/Breathing Problems	☐☐ Eye disorders/Blindness	☐☐ Nose/Throat Disorder	
☐☐ Autism/ASD	☐☐ Fainting/Dizziness/Headaches	☐☐ Nutritional Disorder	
☐☐ Bleeding tendency	☐☐ Hayfever/Seasonal Allergies	☐☐ Prolonged Illness	
☐☐ Blood disease/Transfusion	☐☐ Heart Condition/Heart Murmur	☐☐ Rheumatic Fever	
☐☐ Bone disorder	☐☐ Hepatitis	☐☐ Sickle Cell Anemia/Trait	
☐☐ Cancer/ Tumors	☐☐ Hormone Disorder	☐☐ Skin disease	
☐☐ Cerebral Palsy	☐☐ Hyperactivity/ADD/ADHD	☐☐ Speech Problem	
☐☐ Chicken Pox	☐☐ Jaundice	☐☐ Strep Throat	
☐☐ Diabetes/Endocrine problems	☐☐ Kidney/Liver disease	☐☐ Stomach Problems	
☐☐ Down Syndrome	☐☐ Lung disease	☐☐ Tuberculosis	

If yes to any above, please explain _____

Has your child experienced any other physical or mental disorder that is not listed above? ○ Yes ○ No

If yes, please describe _____

Is your child allergic to any of the following drugs?

○ ○ Y N Penicillin or Amoxicillin ○ ○ Y N Erythromycin ○ ○ Y N Codeine ○ ○ Y N Dental Anesthetic

Is your child allergic to any other drugs? Yes ○ No ○ If yes, please list: _____

Is your child allergic to Latex, Red Dye, Eggs or anything else we should be aware of? ○ Yes ○ No

If yes, please list: _____

Is your child presently under the care of a physician for any illness? ○ Yes ○ No

If yes, please explain _____

List ALL drugs or medicines presently being taken: _____

Has your child ever been hospitalized? ○ Yes ○ No

If yes, please give reason(s) and date(s) _____

May we request the release of your child's medical records if necessary? ○ Yes ○ No

Dental History

☐Yes ☐No Has you child ever been to the dentist? Name of dentist & date _____

☐Yes ☐No Has your child experienced any unfavorable reaction from previous dental care?

Explain _____

☐Yes ☐No Does your child's jaw make noise or have pain with chewing, yawning, or wide opening?

☐Yes ☐No Does your child have any untreated injuries or inflamed areas in or around his/her mouth?

☐Yes ☐No Do your child's gums bleed?

☐Yes ☐No Has your child ever received a local anesthetic? Any complications?

Explain _____

☐Yes ☐No Has your child ever has nitrous oxide ("laughing gas")? Any complications?

Explain _____

☐Yes ☐No Does your family home water contain fluoride? Is it well water or city water? _____

☐Yes ☐No Does your child take any vitamins or fluorides (drops or tablets)?

☐Yes ☐No Does your child use a fluoride toothpaste? When are your child's teeth brushed?

☐Upon rising ☐Before bed ☐Right after eating meals or any food

By whom? _____

☐Yes ☐No Does your child have or has he/she had any of the following:

☐Cavities/Toothache ☐Lips/Finger biting ☐Sippy Cup

☐ Thumb/Finger/Pacifier habit ☐Cheek/Tongue chewing ☐ Mouth breathing

☐Sleeping with bottle ☐Gum Infection ☐Trauma ☐Other _____

☐Yes ☐No Does your child have a dental condition about which you are especially concerned?

Explain _____

☐Yes ☐No Is there anything else about your child that you would like for us to know in order to better his/her oral care maintenance?

_____

I give my consent for dental treatment and the use of proper and acceptable methods to complete said treatment for my child, (child's full name) _____.

I accept responsibility for payment of services rendered.

Signature (Parent/Guardian) _____ Today's Date _____

Reviewed by (staff) _____

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HIPPA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM

Date: _____

You may refuse to sign this acknowledgement & authorization. In refusing, we may not be allowed to process your insurance claims. The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE FORM SHOULD I REQUEST TREATMENT OR RADDIOGRAPHS BE SENT TO ANOTHER ATTENDING DOCTOR/FACILITY IN THE FUTURE

_____ _____

Please **print** name of patient | Please **print** your name

_____ _____

Please **sign** your name | Relationship to patient

Your comments regarding Acknowledgements or Consents: _____

_____

PLEASE LIST ANY OTHER PARTIES WHO CANHAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents, and any care taker who can have access to this patient's records)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION VIA: ☐Cell Phone Confirmation ☐Home Phone Confirmation ☐Work Phone Confirmation ☐Text Message to my Cell Phone ☐Email Confirmation ☐Any of the Above

I AUTHORIZE INFORMATION ABOUT MY HEALTH BE CONVEYED VIA: ☐Cell Phone ☐Home Phone ☐Work Phone ☐Text Message ☐Email ☐Any of the Above

I APPROVE BEING CONTACTED ABOUT SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS, or NEW HEALTH INFO on behalf of DFK: ☐Phone Message ☐Email ☐Any Listed ☐None (Opt out)

HIPPA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/LIMITED AUTHORIZATION & RELEASE FORM CONTNUED

In signing this HIPPA Patient Acknowledgement Form, you acknowledge and authorize that our office may recommend products or services to promote your improves health. DFK may or may not receive third party remuneration from these affiliated companies. We, under current HIPPA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

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FINANCIAL POLICY

Thank you for choosing our office for your child's dental treatment. We are committed to their successful treatment! Please understand that payment of your bill is considered part of your child's treatment. The following is a statement of our financial policy, which we ask that you read, understand, and sign prior to any treatment.

- Please be aware that the party bringing the child to Dentistry For Kids is legally responsible for payment of all charges. We cannot send statements to other persons.

- **Payment in full is requested for each appointment as services are rendered for patients with no dental insurance. Patients with insurance will be requested to pay their patient portion at the time services are rendered.** For the convenience of our patients, we accept cash, personal checks (which cannot be postdated), MasterCard, Visa, American Express, Discover, or Care Credit.

- **Dental Insurance –** There is NO direct relationship between our office and your insurance company. The type of plan chosen by you and/or your employer determines your insurance benefits. As such, we have no say in the selection of your insurance company, no control over the terms of your contract, the methods of reimbursement, or the determination of your insurance benefits. **Therefore, we will accept assignment of benefits as a courtesy to you. However, you are responsible for the payment of your account.** Reimbursement for claims filed by Dentistry For Kids should be made to our office. Any payments not received from your insurance company within 45 days of filing will be billed to you. If there is an overpayment on your account by the insurance company, you may call our office upon receiving your explanation of benefits and we will reimburse you within 45 days of your call.

- **Emergency/Consultation Treatment –** All emergency and consultation treatment must be paid in full at the time the service is rendered. **Consultation fee is $135, not including any xrays.**

We recognize that under unusual circumstances an account balance may be incurred. Dentistry For Kids requires that all/any outstanding balance(s) be paid in full within 45 days unless other arrangements have been made. We reserve the right for your understanding of our financial policy.

_____ _____

Parent/Legal Guardian Date

_____ _____

Witness Date