Kids Dental Studio

PATIENT INFORMATION FORM

1. TELL US ABOUT YOUR CHILD

Child's Name:____________________

Preferred Name or Nickname:____________________

Gender: ☐ Male ☐ Female

Childs Birthdate:__________/______ /______ Age:______

Home Phone #:____________________

Home Address:____________________

City:____________ State:______ Zip:______

Child's SS#:____________________

Referred By:____________________

2. WHO IS ACCOMPANYING THE CHILD TODAY?

Name:____________________

Relationship to the Child:____________________

Do you have legal custody of the child? ☐Y ☐N

Is the child adopted? ☐Y ☐N

Is the child in a foster home? ☐Y ☐N

3. MOTHER'S INFORMATION

Name:____________________

☐Mother ☐Stepmother ☐Guardian Birth date:____ /____ /____

SS#:____________ DL#:____________

Home Address:____________________

City:____________ State:______ Zip:______

Cell #:____________ Work #:____________

Email Address:____________________

Preferred Contact method ☐Home# ☐Cell# ☐Email

4. FATHER'S INFORMATION

Name:____________________

☐Father ☐Stepfather ☐Guardian Birth date:____ /____ /____

SS#:____________ DL#:____________

Home Address:____________________

City:____________ State:______ Zip:______

Cell #:____________ Work #:____________

Email Address:____________________

Preferred Contact method ☐Home# ☐Cell# ☐Email

5. PERSON RESPONSIBLE FOR ACCOUNT

Name:____________________

Birth date:____ /____ /____

SS#:____________ DL#:____________

Billing Address:____________________

City:____________ State:______ Zip:______

Home #:____________ Work #:____________

Cell #:____________________

Employer:____________________

6. DENTAL INSURANCE INFORMATION

Insurance Company:____________________

Claims Address:____________________

City:____________ State:______ Zip:______

Ins Co Phone #:____________

Group #:____________ ID #:____________

Name of Insured:____________________

Relationship to Patient:____________________

SS# of Insured:____________________

Birth Date of Insured:____________________

Insured's Employer:____________________

7. PLEASE READ AND SIGN BELOW

All payments are due at time of service. However, most insurance plan benefits can be used for treatment in our office. Please check with your insurance plan administrator for more details. **During your visit, we will collect what we estimate your insurance will not pay. Actual insurance reimbursement may vary from our estimate. You are responsible for the full balance on your account.** In the case of divorce or separation the parent that brings the child in for the visit is responsible for payment at the time of the visit. Please see our insurance specialist or business manager with any questions.

I have read and understand this insurance policy and hereby authorize my insurance company to send payments directly to Kids Dental Studio and understand that I am responsible for all remaining balances.

Signature:____________________ Date:___/____ /____

Kids Dental Studio

8. MEDICAL HISTORY

Child's Name: ______________________________

Child's Physician: ______________________________

Address: ______________________________

Phone Number: ______________________________

Date of Last Visit: ______________________________

Does your child take any medications? ☐Y ☐N
If yes, please list medications and include dosage:

____

Are immunizations up to date? ☐Y ☐N

Has your child been treated in an emergency room? ☐Y ☐N

If yes, please explain: ______________________________

Has your child been hospitalized or had surgery? ☐Y ☐N

If yes, please explain: ______________________________

Has your child ever had any of the following conditions?

☐Y ☐N Heart Murmur
☐Y ☐N Rheumatic Fever
☐Y ☐N Artificial Heart Valves
☐Y ☐N Congenital Heart Defect
☐Y ☐N Scarlet Fever
☐Y ☐N Cancer/Tumors
☐Y ☐N Chemotherapy
☐Y ☐N Jaw Problems (TMJ/TMD)
☐Y ☐N Hearing/Visual Problems
☐Y ☐N Heart Problems
☐Y ☐N Seizures/Epilepsy
☐Y ☐N Tonsillitis
☐Y ☐N Respiratory Problems
☐Y ☐N Asthma/Difficulty Breathing
☐Y ☐N Seasonal Allergies
☐Y ☐N Blood Transfusion
☐Y ☐N Leukemia
☐Y ☐N Anemia
☐Y ☐N Diabetes
☐Y ☐N Hypoglycemia
☐Y ☐N Hemophilia
☐Y ☐N Abnormal Bleeding
☐Y ☐N Cleft Lip/Palate
☐Y ☐N Birth Defects
☐Y ☐N High Blood Pressure
☐Y ☐N Low Blood Pressure
☐Y ☐N Thyroid Problems
☐Y ☐N Sickle Cell
☐Y ☐N Hepatitis
☐Y ☐N Artificial Bones/Joints
☐Y ☐N Liver/Kidney Problem
☐Y ☐N HIV/AIDS
☐Y ☐N Tuberculosis (TB)
☐Y ☐N Hyperactive/ADD
☐Y ☐N Autism
☐Y ☐N Behavioral Problems
☐Y ☐N Mental/Physical Delay
☐Y ☐N Pregnancy

Allergic to:

☐Y ☐N Latex
☐Y ☐N Tetracycline
☐Y ☐N Penicillin/Amoxicillin
☐Y ☐N Food Allergies
☐Y ☐N Aspirin

Other: ______________________________

9. DENTAL HISTORY

Previous Dentist: ______________________________

Date of last exam: ____/____/____ Date of last x-rays: ____/____/____

Reason for today's visit: ☐Exam ☐Consultation ☐Emergency

How often does your child floss? ______________________________

How often does your child brush? ______________________________

Who brushes your child's teeth? ______________________________

Is your child bottle fed or breast fed? ______________________________

Does your child take fluoride supplements? ☐Y ☐N

Is your child's water fluoridated? ☐Y ☐N

Please check any of the following that apply to your child:

☐ Bad Breath
☐ Bleeding Gums
☐ Clicking or Popping Jaw
☐ Food Collection Between Teeth
☐ Grinding Teeth
☐ Loose Teeth or Broken Fillings
☐ Injury to Face or Mouth
☐ Sensitivity to Cold/Heat
☐ Sensitivity to Sweets
☐ Sores or Growth in Mouth
☐ Mouth Breathing
☐ Thumb/Finger Sucking
☐ Pacifier Sucking
☐ Lip Biting
☐ Nail Biting

10. PLEASE READ AND SIGN BELOW

I affirm that the information I have given on this form is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes in my child's medical status.

Signature: ______________________________ Date: ____/____/____

Dr. Signature: ______________________________ Date: ____/____/____

General Consent for Treatment

I hereby authorize and direct Kids Dental Studio, with the support of licensed dentists and/or dental auxiliaries, to perform upon my child the following dental treatments or oral surgery procedures including the necessary or advisable local anesthesia, radiographs (x-rays), photographs, or diagnostic aids. In general terms, the dental procedures may include one, or a number of the following:

1. Cleaning of the teeth and application of fluoride
2. Application of sealants to the grooves of teeth
3. Treatment of diseased or injured teeth with dental restorations
4. Stainless steel crowns
5. Extraction (removal) of one or more teeth
6. Treatment of diseased or injured oral tissues (hard and/or soft)
7. Treatment of malposed (crooked) teeth and/or developmental abnormalities with fixed or removable orthodontic appliances
8. Behavior guidance through the use of mouth prop, tell-show-do method, and/or voice control
9. Protective stabilization including holding my child or the use of a papoose board
10. Use of sedation medications and/or nitrous oxide to control apprehension
11. Space maintainer(s) to prevent shifting of teeth

I authorize the doctor to do whatever is deemed advisable if any unforeseen condition arises in the course of these designated operations and/or procedures calling, in their judgement, for procedures in addition to or different from those now contemplated.

I consent to the administration of local or general anesthesia, antibiotics, analgesics, or any other drugs that may be deemed necessary in my case, and understand that there is a slight element of risk inherent in the administration of any drug or anesthesia. The risk includes adverse drug response (e.g. allergic reactions), cardiac arrest, aspiration, thrombophlebitis (e.g. irritation and swelling of a vein), pain, discoloration and injury to blood vessels and nerves which may be caused by injections of any medications or drugs, and in very rare cases death. I am informed and fully understand that inherent in any type of surgery are certain unavoidable complications. In oral surgery, the most common of these complications include post-operative bleeding, swelling or bruising, discomfort, stiff jaws, loss or loosening of dental restorations. Less common complications can include infection, loss or injury to adjacent teeth and soft tissues, temporary or permanent nerve disturbances (e.g. numbness in the mouth, lips, tongue, face), jaw fractures, sinus exposure, swallowing or aspiration of teeth and restorations, and small root fragments remaining in the jaw which may require extensive surgery for removal.

I realize that in spite of the possible complications and risks, my contemplated surgery/treatment is necessary and desired by me. I am aware that the practice of dentistry and surgery is not an exact science, and I acknowledge that no guarantees have been made to me concerning the results of the operation or procedure.

I have had the opportunity to ask questions and receive answers to and responsive explanations for, all questions about my medial condition, contemplated and alternative treatments, and the risk and potential complications of the contemplated and alternative treatments, prior to signing this form.

Patient Name:______________________ Date:______________________

Signature of Parent or Guardian______________________ Date:______________________

Witness:______________________ Date:______________________

GENERAL OFFICE POLICIES

A parent/legal guardian must accompany each child to all dental visits. Only a parent/legal guardian can consent to treatment or fill out a child's medical history.

SCHEDULED APPOINTMENTS

We attempt to schedule appointments at your convenience and whenever time is available. Preschool children and school children requiring extensive dental treatment are best seen in the morning when they are fresher and well rested because they tend to be more cooperative, which allows for a more comfortable experience for the child. In order to allow the best possible care for our patients, we reserve a specific time for your child and make every effort to see him/her as scheduled. We appreciate your promptness and your consideration in not changing your scheduled time. **However, if you need to change your child's appointment, a 24-hour notification is required. If this requirement is not met, a $30 charge may be added to your account.**

PAYMENT RESPONSIBILITY

All payments are due at time of service. We accept cash, debit, checks, and most major credit cards. In the event of a returned check, you will be responsible to pay the full balance with another method of payment within 3 days of notification by our office. You will also be responsible for all bank charges/fees incurred and a $35 charge from Kids Dental Studio.

While our office participates in many insurance plans, we are not responsible for how your insurance company handles your claims or for what benefits they pay on a claim. **You are responsible for the full balance on your account.** During your visit, we will collect what we estimate to be your portion of the cost of treatment. (Actual insurance reimbursement may vary from our estimate.) In the event we do not receive payment from your insurance company after 30 days from the date of service, you will be responsible for the remaining balance of all completed treatments. In the case of divorce or separation, the parent that accompanies the child is responsible for payment at the time of visit.

Certain procedures such as the placing of composite (white) fillings or the use of nitrous oxide (laughing gas) may not be covered by your insurance. Please consult your insurance carrier to review the specific coverage details of your plan.

X-RAY RECORDS

By law, x-rays taken here are the property of this office. If for some reason you need a copy of your x-ray records, a **$25 processing fee** will be required prior to delivery of the x-rays.

COLLECTION POLICY

Accounts unpaid after 30 days from the date of service are subject to a 1.5% finance charge, per month. Kids Dental Studio will take necessary steps to collect outstanding balances for accounts greater than 90 days past due. You agree to pay for all the incurred collection costs, court costs, and attorney fees if your account is referred to a collection agency or small claims court.

I have read this document in its entirety and agree to abide by the office policies of Kids Dental Studio. I also authorize my insurance carrier to send payments directly to Kids Dental Studio and understand that I am responsible for all remaining balances.

Patient's Name ______________________________

Parent/Guardian Signature ______________________________

Date ____________________ Witness ____________________

NOTICE OF PRIVACY FORM

Acknowledgement of Receipt of HIPAA Notice of Privacy Practices

I acknowledge that I have received a copy of Kids Dental Studio's HIPAA Notice of Privacy Practices.

____

Print Patient's Name

______________________________ ______________________________

Signature of Patient | Date

OR

____

Signature of Personal Representative

☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Other ______________________________

Please Note: It is your right to refuse to sign this acknowledgement.