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: ___/___/___

Kids Dental Studio

GENERAL CONSENT FOR TREATMENT

I hereby authorize and direct Kids Dental Studio, with the support of licensed dentists and/or dental auxiliaries, to provide any diagnostic (such as X-rays or Photographs) and dental procedures necessary for proper dental care. 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 will have the opportunity to ask questions and receive answers for all questions regarding my (or my child's) treatment.

I authorize Kids Dental Studio to disclose any records necessary to carry out treatment or for insurance and payment purposes.

A parent/legal guardian must accompany each child to all dental visits.

GENERAL OFFICE POLICIES

SCHEDULED APPOINTMENTS

We attempt to schedule appointments at your convenience and whenever time is available. We appreciate your promptness and your consideration in not changing your scheduled time. However, if you need to change your child's appointment, a 48-hour notification is required. If this requirement is not met, **a $50 charge for EACH appointment** may be added to your account. This fee will need to be paid before any additional appointments can be made.

Two or more missed appointments without a 48-hour notification would be cause for dismissal from the practice.

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 (not to exceed $20 or as permitted by law).

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.

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 and fees if your account is referred to a collection agency.

To protect the privacy of our all patients and staff, there is **No Photography, Videotaping, or Recording** of any kind allowed in the treatment rooms. We appreciate your understanding.

I have read this document in its entirety and agree to abide by the office policies of Kids Dental Studio.

Patient's Name_____

Parent/Guardian Signature_____

Date_____ Witness _____

Kids Dental Studio

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.