kids care DENTAL & ORTHODONTICS™

Dental New Patient Information

PATIENT INFORMATION

Patient Name *(Last, First, M.I.):* ☐ M ☐ F		Birthdate:
Street Address:		Phone:
City: State: Zip:		Email:
What is the reason for your child's visit today?		
Emergency Contact Name:	Relationship:	Emergency Work Phone:
Emergency Address:		Emergency Cell Phone:

LEGAL GUARDIAN #1/PRIMARY CONTACT

Name of Primary Contact *(Last, First, M.I.):*		
Relationship to Patient:	☐ M ☐ F	Birth Date:
Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated		
Social Security #:	Driver's License #:	State of Issuance:
Email:	Mobile #:	Work #:
Street Address:		
City:	State:	Zip:

LEGAL GUARDIAN #2/SECONDARY CONTACT (IF APPLICABLE)

Name of Secondary Contact *(Last, First, M.I.):*		
Relationship to Patient:	☐ M ☐ F	Birth Date:
Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated		
Social Security #:	Driver's License #:	State of Issuance:
Email:	Mobile #:	Work #:
Street Address:		
City:	State:	Zip:

HOW DID YOU HEAR ABOUT US? (CHECK ONE)

☐ Mail/Print ☐ Event ☐ Online Ad ☐ Social Media (ex. Facebook)
☐ Drive-by/Walk-in ☐ Google/Search ☐ Email ☐ Other
☐ Radio/TV ☐ Insurance Directory ☐ Review Website (ex. Yelp)
☐ Referred by a Kids Care Dental patient? If so, please list their name:
☐ Referred by a pediatrician or a general dentist? If so, please list their name:

FAMILY INFORMATION	
Name(s) of Children	
Name:	Date of Birth:
Name:	Date of Birth:
Name:	Date of Birth:
Name:	Date of Birth:

INSURANCE INFORMATION (PRIMARY & SECONDARY)			
Name of Primary Insured (Last, First, M.I.):			
Patient's Relationship to Primary Insured:	Insured's Birth Date:	☐ M ☐ F	
Insured's Street Address:			
City:	State:	Zip:	
Employer Name:	SSN #:		
Primary Insurance Name:	ID #:	Group #:	
Primary Insurance Street Address:			
City:	*State:*	*Zip:*	
Name of Secondary Insured (Last, First, M.I.):			
Patient's Relationship to Secondary Insured:	Insured's Birth Date:	☐ M ☐ F	
Insured's Street Address:			
City:	State:	Zip:	
Employer Name:	SSN #:		
Secondary Insurance Name:	ID #:	Group #:	
Secondary Insurance Street Address:			
City:	State:	Zip:	

HEALTH INFORMATION

Has the patient ever had any of the following? Please check all that apply:

☐ Abnormal Bleeding	☐ Autism	☐ Hepatitis	☐ Seizures/Convulsions
☐ ADD/ADHD	☐ Cancer/Tumor	☐ High Blood Pressure	☐ Sickle Cell Disease/Trait
☐ AIDS/HIV+	☐ Diabetes	☐ Kidney Problems	☐ Sinus Problems
☐ Anemia	☐ Epilepsy	☐ Liver Problems	☐ Tuberculosis (TB)
☐ Artificial Joints/Valves	☐ Gluten Intolerance	☐ Rheumatic Fever	☐ Vitamin B12 Deficiency
☐ Asthma	☐ Hemophilia	☐ Scarlet Fever	

Additional Questions:

Have there been any changes in your child's general health in the past year?	☐ Yes	☐ No
Is your child currently under the care of a physician? If yes, please explain below.	☐ Yes	☐ No
We use disclosing tablets and solutions to reveal harmful bacterial plaque on teeth. These disclosing products DO contain food dyes. Do you or your child have any food dye allergies?	☐ Yes	☐ No
Is your child subject to nervous disorders, fainting or dizziness?	☐ Yes	☐ No
Is your child subject to blood or bleeding disorders?	☐ Yes	☐ No
Does your child bruise easily?	☐ Yes	☐ No
Does your child have a history of seasonal allergies?	☐ Yes	☐ No
Is your child allergic to latex?	☐ Yes	☐ No
Has your child ever had any issues, complications or negative experiences with any medical or dental treatment?	☐ Yes	☐ No
Does your child have a history of any of the following: Congenital Heart Defect, Mitral Valve Prolapse, Irregular Heartbeat or ANY other heart condition?	☐ Yes	☐ No

If yes, please explain:

Does the patient have any health problems that need further clarification?	☐ Yes	☐ No

If yes, please explain:

Supplemental Questions for Ages 12+:

Has your child experienced puberty?	☐ Yes	☐ No
Is your child pregnant or nursing?	☐ Yes	☐ No
Is your child on birth control?	☐ Yes	☐ No

Please list all drugs that the patient is currently taking:

Please list all allergies the patient has (i.e. Penicillin):

Name of Physician:	Date of Last Visit:
Physician Address:	Phone:

DENTAL HEALTH INFORMATION

Is this your child's first dental visit? If not, how long since last visit?	☐ Yes	☐ No
Were x-rays taken at the previous dentist?	☐ Yes	☐ No
Have there been any injuries to the teeth, face or mouth? If yes, please explain:	☐ Yes	☐ No
Has your child ever had any pain or tenderness in his/her jaw join (TMJ/TMD)?	☐ Yes	☐ No
Does your child brush his/her teeth daily?	☐ Yes	☐ No
Does your child floss his/her teeth daily?	☐ Yes	☐ No
Is your child taking a fluoride vitamin supplement or drinking fluoridated water?	☐ Yes	☐ No
Does your child need or has it ever been recommended or required that your child take an antibiotic pre-medication prior to dental treatment?	☐ Yes	☐ No

Has the patient ever experienced any of the following? Please check all that apply:

☐ Breast Fed	☐ Lip Sucking/Biting	☐ Speech Problems	☐ Used Pacifier
☐ Bottle Habits	☐ Mouth Breather	☐ Thumb/Finger Sucking	
☐ Clenching/Grinding Teeth	☐ Nail Biting	☐ Tongue Thrust	

I understand that the information I have given is correct to the best of my knowledge and that it is my responsibility to inform this office of any changes in medical history.

Signature: Date:

Signature of Dentist:

HIPAA NOTICE OF PRIVACY PRACTICES

Signature below is acknowledgement that you have received and understand the HIPAA Notice of Privacy Practices.

Signature: Date:

CONSENT TO TREATMENT OF A MINOR

To allow for treatment of patients who are considered minors, it is necessary for a parent or legal guardian to give consent for treatment. In the event that a minor child presents for a non-urgent appointment without a parent or legal guardian or a signed consent, treatment may be denied.

AUTHORIZATION

Under the California Family Code, I have the legal right to authorize Kids Care Dental and its personnel to deliver routine dental treatment and services to my child. Routine dental care may include, but is not limited to: dental examinations, prophylaxis (cleaning), fluoride treatment, x- rays and any other treatment plan previously discussed and agreed upon by the parents/legal guardian.

I _____(print parent/legal guardian name) request and authorize Kids Care Dental and its personnel to deliver routine dental care to my child as may be deemed necessary or advisable in the diagnosis and treatment of my child. Also, my child lives in my home and I am 18 years of age or older.

Child Name:	
Signature:	**Date:**

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I _____ (print parent/legal guardian name), hereby authorize Kids Care Dental to release my child's health information to the following person(s):
(Please list secondary contact(s) other than the Parent/Guardian, such as: Babysitter, Caretaker, etc.)

Name:	**Phone:**
Name:	**Phone:**
Name:	**Phone:**

I acknowledge and consent that Kids Care Dental is permitted to release Protected Health Information to the individual's named above should they accompany my child to an appointment.

I authorize _____to consult with Kids Care Dental about my child's dental care, to approve of a modification in the care provided, and to agree to the financial terms that resulted from such change in the care provided.

I understand that by signing this authorization:

- I authorize the use or disclosure of my child's individually identifiable health information.
- I have the right to withdraw permission for the release of my child's information. If I sign this authorization to use or disclose information, I can revoke that authorization at any time. The revocation must be made in writing and will not affect information that has already been used or disclosed.
- I have the right to receive a copy of this authorization.
- I am signing this authorization voluntarily and treatment, payment, or my child's eligibility for benefits will not be affected if I do not sign this authorization.
- I further understand that a person to whom records and information are disclosed pursuant to this authorization may not further use or disclose the medical information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

By signing below, you are confirming that you are the parent and/or legal guardian of the above named minor and can provide confirmation through legal documentation. You also agree that you are aware of the office policy and guidelines when performing dental treatment on a minor child. You, the parent or legal guardian, agree to abide by these guidelines and follow this policy. Warning: Do not sign this form if any of the statements above are incorrect, or you will be committing a crime punishable by a fine, imprisonment, or both.

Parent/Legal Guardian Signature:	**Date:**
Parent/Legal Guardian Residence:	**DL# or ID#:**

OFFICE POLICIES

At Kids Care Dental, our mission is to deliver an awesome dental visit to every person, every time. We want to deliver high quality care in an environment that provides personalized attention for each guest. That's why our office policies are designed with the patient in mind. Please read through our policies carefully.

INITIAL

Financial Policy – It is our policy to receive the patient's portion of payment in full at the time of service.
Our office works with most insurance companies and we will bill them as a courtesy to you. For your convenience, we accept cash, personal checks, money orders, and credit card payments at the time of service. The practice also has special arrangements with a few financial institutions (CareCredit and DentalBanc) that may also fit your needs.

INITIAL

Insurance and Authorization – We would be happy to file a dental claim with your insurer on your behalf, but you are ultimately responsible for all charges.
We do ask that you read your policy thoroughly so that you are fully aware of the benefits provided and the limitations imposed. You should be aware that different insurance companies vary greatly in the types of coverage available and that some companies take care of claims promptly and others delay payment for many months. We will do everything possible to see that you receive the full benefits of your policy; however we cannot guarantee any estimated coverage. By signing this document, you agree that you are ultimately responsible for payment of services rendered and responsible for paying any co-payment and deductible that your insurance does not cover. You also authorize Kids Care Dental & Orthodontics to release all information necessary to secure the payment of benefits and assign directly to Kids Care Dental & Orthodontics all insurance benefits otherwise payable to you.

INITIAL

Estimates – We will give you an ESTIMATE for your portion based on the information given to us by your insurance carrier.
Please remember that this is ONLY an estimate. We will provide you with written treatment plans at your new patient exam and all recall (six month checkup) appointments. A treatment plan estimate includes our fee, what insurance is ESTIMATED to cover and what your out of pocket expenses will be. If you have insurance, you must remember that these are only estimates based on the information provided. Treatment plans may change depending on the needs of your child. We will always do our best to keep you informed of any changes.

INITIAL

Broken Appointments – We ask that you give us at least 24 hours' notice before cancelling an appointment.
Because of the personalized care that Kids Care Dental & Orthodontics provides, your child's appointment time is reserved just for them. While we understand that emergencies sometimes arise, in order to be respectful of the needs of all patients we ask that if your child is unable to attend their next appointment, please call our office at least 24 hours in advance. No show appointments and appointments cancelled with less than 24 hours' notice may be subject to a $50.00 cancellation fee.

INITIAL

Release of Liability and Assumption of Risk – I acknowledge that enjoyment of various play activities at Kids Care Dental (including the carousel and playground) is based upon my, as the parent or guardian of minor, executing this Release of Liability and Assumption of Risk.
I further acknowledge that my child or minor ward is voluntarily participating in these activities. I understand there are numerous risks and dangers involved in these activities including but not limited to: falling off of the equipment or otherwise injuring oneself on or near the equipment; experiencing electric shock; or the negligence (but not willful or fraudulent conduct) of Kids Care Dental & Orthodontics, and all of their employees, all of which may lead to injury or death. I hereby agree to assume all risks and dangers to my child or minor ward, whether or not listed herein. Additionally, I hereby release and waive on behalf of my child and, if applicable, my minor ward, to the extent permitted by law, all claims or causes of action against Kids Care Dental & Orthodontics and all of their affiliates, officers, directors, shareholders, employees, contractors, agents, heirs, and assigns. By initialing this Release of Liability and Assumption of Risk, I acknowledge that I have read and understand the provisions contained herein.

I have reviewed the office policies and have been given the opportunity to ask questions to clarify any policy I did not understand.

Signature: **Date:**

Print Name: