My Kidz Dentist

"Dentistry for infants, children, teenagers and special needs patients"

Today's Date_____ Who may we thank for this referral?_____

PATIENT INFORMATION ...

First Name_____ M.I._____ Last Name_____ Nickname_____

Sex: ☐ Male ☐ Female Birthdate _____ Age_____ School_____ Grade_____

Home Address_____ Apt_____ City_____ State_____ Zip_____

Home Phone ( )_____ Cell Phone ( )_____

Previous Dentist_____ Medical Doctor_____ Phone ( ) _____

Whom Does the child live with? ☐ Mother ☐ Father ☐ Joint Custody ☐ Guardian ☐ Grandparents

How May we send appointment reminder? ☐ Phone ☐ Text ☐ Email

RESPONSIBLE PARTY (THIS IS PERSON SIGNING THIS FORM AND BRINGING CHILD IN)

☐ Mother ☐ Father ☐ Guardian other_____ First Name_____ last Name_____

S.S.# _____ Birth Date_____ Age_____ home ( )_____ Work ( ) _____ Cell ( ) _____

☐ **SAME AS ABOVE**

Street_____ Apt_____ City_____ State_____ Zip_____

Driver's License # _____ Employer_____

Email_____

SPOUSE OR OTHER GUARANTOR (IF DIFFERENT FROM ABOVE)

☐ Mother ☐ Father ☐ Guardian Other First Name_____ Last Name_____

S.S.# _____ Birth Date_____ Age_____ Home___( ) _____ Work_____( ) _____ Cel( )_____

☐ **SAME AS ABOVE**

Street_____ Apt_____ City_____ State_____ Zip_____

Driver's License # _____ Employer_____

Email_____

PLEASE LIST INDIVIDUALS YOU GIVE PERMISSION TO BRING TO APPOINTMENTS (MUST BE AT LEAST 18 YEARS OLD).

First Name_____ Last Name_____ Phone ( )_____ Relationship_____

First Name_____ Last Name_____ Phone ( )_____ Relationship_____

First Name_____ Last Name_____ Phone ( )_____ Relationship_____

Insurance Information...

PRIMARY DENTAL INSURANCE

Subscriber_____ Relation_____

Birth Date_____ S.S.#_____

☐ SAME AS ABOVE

Street_____ City_____

State_____ Zip_____ Phone( ) _____

Employer_____

Ins. Co. Name_____ I.D. #_____

Address_____

_____ Phone ( )_____

Group #_____

SECONDARY DENTAL INSURANCE

Subscriber_____ Relation_____

Birth Date_____ S.S.#_____

☐ SAME AS ABOVE

Street_____ City_____

State_____ Zip_____ Phone( ) _____

Employer_____

Ins. Co. Name_____ I.D. #_____

Address_____

_____ Phone ( )_____

Group #_____

Fees and Payments

We make every effort to keep down the cost of your care. You can help by paying prior to treatment. If you have any dental insurance, as a courtesy to you, we will promptly fill out proper forms and submit the claims to your insurance. Upon request, I understand a pre-authorization of beneifits to my insurance company may be submitted to allow me to know what insurance reimbursement will be prior to the start of treatment.

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Your Insurance policy is a legal agreement between yourself and the insurance company. My child's treatment fees are an agreement between myself and **My Kidz Dentist** . Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is your responsibility to pay any deductible amount, co-insurance or any other balance not paid by your insurance company. You will responsible for all collection cost, attorney fees, and court costs. I authorize the release of information necessary to process my claim and authorize payment of the benefits.

By signing this agreement, I understand the treatment objectives and treatment plan and approve of the treatment as outlined on the treatment sheet for my child. I understand that all procedures are not always successful even when preformed properly.

X _____ x_____

Signature of Parent or Guardian Date

PATIENT'S DENTAL HISTORY...

Reason for today's visit_____

Is this your child's first visit to the dentist? ☐Yes ☐No If no, date of last dental examination_____

Is this an emergency visit? ☐Yes ☐No If your child is having dental problem, please explain:_____

Please mark if your child is having any problems with these below:

☐ Cavities ☐ Gum infection ☐ Trauma ☐ Orthodontics ☐ Pacifier Use ☐ Color of Teeth ☐ Grinds his teeth

☐ Toothache ☐ Teeth Sensitivity ☐ Nail Biting ☐ Jaw Sounds ☐ Thumb sucking ☐ Other_____

Was your child ☐ Breast fed ☐ Bottle fed At what age did it stop?_____

How often does your child brush daily? ☐ Once ☐ Twice ☐ Seldom ☐ BY parent ☐ By child ☐ Both

How often does your child floss? ☐ Once daily ☐ Occasionally ☐ Never ☐ By parent ☐ By child ☐ Both

How do you think your child will react to this dental visit? ☐ Cooperative ☐ Uncooperative ☐ Not sure

MEDICAL HISTORY...

Is your child under the care of a physician? ☐ Yes ☐ No If yes, Why?_____

Has your child been hospitalized? ☐ Yes ☐ No If yes, when and why?_____

Allergies_____Allergies to medications_____

Is your child currently taking any medications? ☐ Yes ☐ No If yes, please list:_____

DOES YOUR CHILD HAVE OR HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING CONDITIONS?

Anemia	☐Yes	☐No	Emotional Problems	☐Yes	☐No	Pregnant	☐Yes	☐No
Asthma	☐Yes	☐No	Epilepsy	☐Yes	☐No	Psychiatric Problems	☐Yes	☐No
Autism	☐Yes	☐No	G-tube Feeding	☐Yes	☐No	Radiation Therapy	☐Yes	☐No
Birth Defects	☐Yes	☐No	Hearing Impairment	☐Yes	☐No	Rheumatic Fever	☐Yes	☐No
Bleeding Problems	☐Yes	☐No	Heart Condition	☐Yes	☐No	Seizures	☐Yes	☐No
Blood Disorders	☐Yes	☐No	Heart Murmur	☐Yes	☐No	Sexually Trans. Diseases	☐Yes	☐No
Blood Transfusions	☐Yes	☐No	Hepatitis	☐Yes	☐No	Sickle Cell Anemia	☐Yes	☐No
Cancer	☐Yes	☐No	Herpes	☐Yes	☐No	Skin Disorders	☐Yes	☐No
Cerebral Palsy	☐Yes	☐No	High Blood Pressure	☐Yes	☐No	Sleep Apnea	☐Yes	☐No
Cleft Lip/palate	☐Yes	☐No	HIV/AIDS	☐Yes	☐No	Snoring	☐Yes	☐No
Chronic Ear Infection	☐Yes	☐No	Hyperactivity/ADHD	☐Yes	☐No	Spin Bifida	☐Yes	☐No
Cystic Fibrosis	☐Yes	☐No	Kidney Disease	☐Yes	☐No	Tuberculosis	☐Yes	☐No
Delayed Speech	☐Yes	☐No	Learning Disabilities	☐Yes	☐No	Tumors	☐Yes	☐No
Development Delay	☐Yes	☐No	Liver Disease	☐Yes	☐No	Syndrome (specify)_____		
Diabetes	☐Yes	☐No	Mental Retardation	☐Yes	☐No			
Down Syndrome	☐Yes	☐No	Muscular Dystrophy	☐Yes	☐No			

PLEASE LIST ANY ADDITIONAL MEDICAL CONCERNS:_____

CLINICAL NOTES:

HEALTH HISTORY

To the best of my knowledge, the indicated health history remains current and any changes in the patient's health or medications will be updated. I will not hold my doctor or staff responsible for any errors or omissions that I have made in completion of this form. I understand that withholding this information may effect the outcome of the procedure(s) or course(s) of treatment. I give consent for the doctors of MKD to complete a throrough examination on the patient previously named, including any needed radiographs.

X_____ X_____

Signature of Parent or Guardian Date

HIPPA

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed. I understand that my health care and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask any questions I may have regarding this Notice.

X_____ X_____

Signature of Parent or Guardian Date

MY KIDZ DENTIST

OFFICE/FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you and your child (ren). Your complete understanding of our office and financial policies are an essential element of your child (rens) care and treatment. If you have any questions please discuss them with our front office staff prior to treatment.

As a courtesy, we will be happy to file your primary insurance benefits, though we are not obligated to do so. Your dental insurance plan is a contract between you, your employer and the insurance company. Our office does not determine your dental benefits. Many carriers will not reimburse our office because we are a specialist. In this instance, you will be responsible for the costs of each visit at the time services are provided and your insurance company will send you the reimbursement check directly. **Any amount not covered by insurance is payable at the time services are rendered.** These fees may include deductibles, co-payments or certain procedures not covered by your insurance policy. Unfortunately some of the services that we may recommend for your child will not be covered by your specific dental insurance.
We will allow a maximum of 30 days for your insurance company to clear account balances. If your insurance has denied your claim due to the lack of information, we will look to you for payment and encourage you to call your insurance company to make sure they have the proper information. **Any unpaid portions will be due in full by you, after this period.**

FINANCIAL POLICY:

Change in Insurance Plan: You are expected to notify our office if your insurance coverage has changed. Our office will periodically ask you to update your records. We are to be provided with full and complete information in order for our office to bill the correct insurance company for you.

Financing Programs: To help provide cost effective care to our patients, we offer the **Care Credit** financing program for both dental and orthodontic treatment. We do not offer payment plans.

Financial Obligation: After attempts to collect outstanding funds and a 90 day grace period from the time of service, parents/guardians not fulfilling their financial obligation will be sent to collections as stipulated by our accountants. You will be responsible for any legal fees. In addition to your balance, 35% of the balance due will be assessed as a collection fee/cost.

Method of Payments: For your convenience we accept cash, debit/credit cards (Visa, MasterCard, American Express and Discover Card).

Non-Insured Patients: We offer a 10% cash discount for patients with NO INSURANCE. Payment method is CASH ONLY and applies to balances of $100.00 or more. We don't offer this discount to patients who are enrolled in any type of dental discount plan.

OFFICE POLICY:

One Parent Policy: We allow one parent/guardian back in the treatment rooms, no other siblings or children will be allowed. If you have other children, please make prior child care arrangements. If you need to bring other children to an appointment you will be asked to wait in the waiting room with them.

Divorced Parents: The parent bringing the child (ren) for their dental appointment will be considered the **RESPONSIBLE PARTY**. If you share financial responsibility it is up to the responsible party to pay on the account and seek reimbursement.

Missed Appointments: Our office requires a 24-hour notification if you need to cancel or reschedule an appointment. Failure to contact our office in advance will result in a $25.00 fee billed to your account.

Office hours: Mondays thru Thursdays 7:30am-4:30pm & Fridays 7:30am to 1:30pm

I acknowledge receipt of the office and financial policies. I understand that this office cannot make an exact estimate of insurance benefits since it does not have access to all insurance company records. I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice. I assume all financial responsibility even though I may have dental benefits.

Child's Name: _____ Date of Birth_____

_____ Date:

_____
Signature of Parent/Guardian

_____
Please print name of Parent/Guardian