Your Ticket To A Great Smile!

Child's Information

Date _____/_____/_____

Child's Name_____Preferred Name_____
(Last) (First) (Middle)

Date of Birth _____/_____/_____ ☐ Male ☐ Female Social Security# _____/_____/_____

Child's Address_____ Child's Home # _____/_____/_____

City_____ State_____ Zip _____

School Attending _____ Grade _____

Emergency Contact (***Other than Parent***) _____ Phone#_____/_____/_____ Relationship: _____

Parent's Marital Status ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Mother's Information ☐Parent / Guardian ☐ Step Mother

Mother's Name_____ Address Same As Child's ☐Yes ☐ No
(Last) (First) (Middle)

Address _____ Email _____

City_____ State _____ Zip _____ Date of Birth _____/_____/_____

Home # _____/_____/_____ Cell # _____/_____/_____ Social Security# _____/_____/_____

Employer _____ Work # _____/_____/_____ Ext _____

Father's Information ☐ Parent / Guardian ☐ Step Father

Father's Name_____ Address Same As Child 's ☐Yes ☐ No
(Last) (First) (Middle)

Address _____ Email _____

City _____ State _____ Zip _____ Date of Birth _____/_____/_____

Home # _____/_____/_____ Cell # _____/_____/_____ Social Security# _____/_____/_____

Employer _____ Work # _____/_____/_____ Ext _____

Dental Insurance Information

Primary Insured Name_____

Date of Birth _____

Contract/ ID # _____

Group # _____ Policy #_____

Social Security # _____-_____-_____

Orthodontic Coverage ☐ Yes ☐ No ☐ Not Sure

Authorization to file insurance (initial) _____

Secondary Insurance Name _____

Insured Name _____

Contract / ID #_____

Group # _____ Policy # _____

Social Security # _____-_____-_____

Orthodontic Coverage ☐ Yes ☐ No ☐ Not Sure

Other Information

Name(s) of any Brother(s) or sister(s) _____

Are they currently patients? ☐Yes ☐No Can we help you schedule an appointment if they are not patients? ☐Yes ☐No

How did you hear about Kidiatric Dental?

☐Facebook ☐Instagram ☐Insurance ☐Drive By
☐Sibling is Current Patient ☐Google Search ☐School ☐Social ☐Vendor Event
☐Friend Referral _____ ☐Doctor/Office Referral_____

Please list any favorite interests such as favorite toys, activities or pets that might help us make your child feel more at home:

Please list any sports that your child participates in:

PERMIT FOR DENTAL SERVICES UPON A MINOR (Permission to treat child without parent/guardian present)

I, being the parent or guardian of _____, do hereby authorize and request the performance of dental services, or emergency procedures, that the judgment of the doctor may dictate during treatment. I understand that the treatment may indicate the use of nitrous oxide/oxygen analgesia (laughing gas) as deemed necessary by the doctor unless otherwise noted by me. **Initial** _____

Date _____/_____/_____ Signature _____ Relationship_____

Translated By: _____

Medical History

Child's Name_____
(Last) (First)

Is your child **ALLERGIC** to any of the following? **If YES, please explain what type of reaction occurs:**

☐Antibiotic_____ ☐Latex _____

☐Local Anaesthetics _____ ☐Food _____

☐Any Metals _____ ☐Medication _____

☐ **None of the Above** ☐Other _____

Has your child had a history of:

☐ Heart Murmur	☐ Asthma	☐ Down's Syndrome	☐ Herpes/Cold Sores
☐ Congenital Heart Defect	☐ Anaphylaxis to: _____	☐ Cerebral Palsy	☐ HIV/AIDS
☐ Rheumatic/Scarlett Fever	☐ Tuberculosis (TB)	☐ ID/Delayed Development	☐ Anemia
☐ Kidney/Liver Problems	☐ Stomach/Intestinal Disease	☐ Autism/Sensory Issues	☐ Hepatitis
☐ Convulsions/Epilepsy	☐ Thyroid Disease	☐ Psychiatric Care	☐ Hemophilia
☐ Diabetes	☐ Hearing Impairments	☐ ADHD/ADD	☐ Sickle Cell Disease

☐ Cancer: _____ ☐ Any Operations: _____

☐ Handicaps/Disabilities: _____ ☐ Other: _____

☐ **None of the Above**

Does your child have a heart condition that requires an antibiotic before any dental procedure? ☐Yes ☐No

Please list any medication that your child is currently taking? _____

Is your child currently under the care of a physician? ☐Yes ☐No Date Last Seen _____

Child Physician _____ Physician's Phone Number _____

I understand the information that I have given is correct to the best of my knowledge and that it will be held in the strictest of confidence. It is also my responsibility as the parent/ guardian to inform the office of any changes in my child's medical status.

Signature: _____ Date: _____/_____/_____

Doctor's Signature: _____

Dental History

Child's Name_____
(Last) (First)

What is the purpose of your child's dental visit with us today?

☐ Child' First Visit to Dentist ☐2nd Opinion ☐ Orthodontics

☐ Check Up & Cleaning ☐Mouth or Tooth Pain ☐Other: _____

☐ Exam Only ☐Trauma or Accident to Teeth/Gums

When was your child's last dental visit? _____/_____/_____ (approximate date)

Dentist's Name: _____ Dental Office Name: _____

Has your child had any history of or current use of any of the following (please check all that apply):

☐Toothache ☐Tongue Thrusts ☐Current Pacifier Use ☐Lip Sucking / Biting

☐TMJ (jaw pain) ☐Bleeding Gums ☐Nail Biting ☐Clenching /Grinding

☐Current Thumb or Finger Sucking ☐Sensitivity to Cold/ Hot ☐Trauma to Tooth / Face ☐**None of the Above**

Has your child ever had any unfavorable experience with any previous dental work before? ☐Yes ☐No

If yes, please explain: _____

* Upon request we can offer private rooms for your child's exam. Please let us know when you arrive for your appointment.

Does your child: Brush his/her teeth daily? ☐Yes ☐No Floss his / her teeth daily? ☐Yes ☐No

Has your child ever been seen by an orthodontist? ☐Yes ☐No _____/_____/_____ (approximate date)

I understand the information that I have given is correct to the best of my knowledge and that it will be held in the strictest of confidence. It is also my responsibility as the parent/ guardian to inform the office of any changes in my child's medical status.

Signature: _____ Date: _____/_____/_____

Doctor's Signature: _____

Dental Treatment Acknowledgment

As health professionals, it is necessary that we inform our patients and parents of all the possible treatment and techniques that we use in our office. Please read this form carefully and ask any questions that may not be clear or that you may not understand. ***This is only to inform you of the types of services we provide, which varies from child to child according to their needs. We will ALWAYS advise you of any and all treatment that will be completed before we render ANY services. The highest standard of care of your child is our top priority.***

Please be aware that these are only services & techniques that we offer and are NOT NECESSARILY something that your child will need. Please feel free to ask us if you have questions regarding these items:

- Dental cleaning, fluoride application and digital radiographs, as necessary
- Application of sealants to dental fissures
- Restoration of broken teeth or fillings
- Treatment of infected teeth or gums
- Removal of 1 or more teeth
- Use of behavior management techniques such as "Tell-Show-Do, Modeling, Voice Control, etc" to facilitate communication during the dental visit
- Use of a "Safety Blanket" to protect your child from self-injury during emergencies or scheduled sedation appointments
- Use of local anesthetics
- Use of sedative medication to help increase cooperation and reduce anxiety and discomfort
- Use of Nitrous Oxide to help reduce mild anxiety
- Tenderness, bruising, nausea, vomiting, aspiration, swelling, bleeding, infection, numbness allergic reaction, stroke, heart attack, and death are all possible complications of ANY dental procedure. Some of these complications may require hospitalization. Serious complications are *EXTREMELY* rare.

Although the best results are always expected, within reason, there is no way of anticipating complications. Therefore, it is not possible to guarantee the results or cure of the treatment. Although the occurrence is remote, it is known that some risks are associated with dental procedures. We are required to mention the following: damage to central nervous system, reduction or loss of function of internal organs and limbs, as well as disfiguring scars. I understand and accept that certain complications may be fatal or require medical intervention and that the staff at Kidiatric Dental places the safety of our patients above anything else.

Signature: _____ Date: _____/_____/_____

Child Safety Procedures

When a child needs to have treatment completed beyond exams, x-rays, cleanings, and minor restorations, we ask that parents remain in our relaxation room while their child is being treated with **oral conscious sedation medication**. Often, we are asked by parents "Why can't I remain with my child **during dental treatment**?" To help you understand better, we offer the following reasons:

1. Certain children are more compliant without parental emotional involvement.
2. A ***SEDATED CHILD*** requires the full attention of the staff and doctor. Visitors in the room can cause distractions and the doctor/assistants need to have their full attention on your child *AT ALL TIMES*.
3. Parents in the treatment room often slow procedures with questions, concerns, and suggestions. Due to some procedures, parents may find it difficult to observe, leading to fainting and vomiting. If parents require the doctor's attention, then the safety of the patient is compromised.
4. It is important that the doctor builds rapport with the child and establishes the rules & boundaries of the office. When parents or other adults are in the room, the doctor's authority may be undermined. This can lead to longer appointment times, additional appointments to complete treatment, and possible negative psychological effects for your child.

We are an office dedicated to the quality treatment of children; please know that our office mission is to treat every child as if they were our own. We follow the same parental procedures regardless of sedation level required and will go over our treatment procedures with you personally once any treatment has been diagnosed.

Thank you for your understanding,

Dr. Villanueva and Staff

Signature: _____ Date: _____/_____/_____

Financial Agreement

Insurance and Patient Payments – INSURANCE INFORMATION IS REQUIRED PRIOR TO ALL APPOINTMENTS

If you have informed us, Kidiatric Dental, of the insurance policy that you carry, we will gladly process claims for your child as a courtesy to you. At your first appointment with us, we will gladly give you an ***estimate*** of what your insurance will cover and what your out-of-pocket portion will be. ***Your estimated portion will be due at the time services are rendered***. Your ***insurance carrier*** makes it very clear that they ***will not guarantee any payment*** until the services are billed and reviewed. Please remember that our contracts for your child's dental services are with you and not your insurance carrier. We allow 45 days from the date of service for payment from your insurance carrier. After this period, we will expect payment in full for any unpaid dental services. (****NOTE: Please notify administrative team if you have specific payment arrangements, ie: per Divorce Decree or split parenting.** *You will be required to provide copies of corresponding documents as well as contact information for the parent or guardian not present.)*

Fillings

Composite, or "white" fillings, are the only type of fillings done here at Kidiatric Dental. Your insurance may only give you the benefit of the amalgam, or "silver", fillings. This means that you may be responsible for the cost difference, or the dollar amount cost difference, between the two. Please contact your insurance company with any questions regarding this coverage.

Cancelled/ Missed Appointments

We reserve the right to charge $25.00 for appointments cancelled or missed without 48 hours advanced notice. Two or more missed appointments in one year will result in your child being seen as a walk-in patient.

Records

We reserve the right to charge $30.00 for all copies of records and we kindly request that you allow at least 48 hours for the duplication of x-rays & copying of records.

Finance Charges

We reserve the right to charge 1.5% finance charge monthly on any outstanding/unpaid balances over 30 days.

Collection Policy

We reserve the right to assign any dental account that is unpaid for more than 90 days to a collection agency. The guarantor, or parent, is allowed 2 written statements and at least one phone call, by law. If a payment arrangement is not made after contact attempts, any and all unpaid charges, will be assigned to a collection agency. It is further agreed that the guarantor or parent, will be responsible for all finance charges, collections costs up to 45%, attorney fees and any other costs that may be incurred to enforce collection of any amount outstanding.

Camera/Phone/Video use in Treatment Rooms

Due to HIPAA regulations and to respect the privacy of all of our patients & staff, we do not allow VIDEOTAPING anywhere in the office. PHOTOGRAPHY of your child is encouraged in the hygiene & x-ray stations only. **Please be courteous of other patients & the staff and get express consent prior to including other patients & staff in photos. PHOTOGRAPHY during dental procedures in the treatment room is NOT permitted.** Thank you for your understanding.

Private Rooms

Our office was built around an open bay layout to allow patients to see other children during their appointment. If you would prefer a private room, please feel free to let us know when you first arrive for your child's appointment and we would be more than happy to accommodate you.

Privacy Policy

Our commitment at Kidiatric Dental is to serve our patients with care and professionalism, being sure at all times to PROTECT the privacy and security of all Protected Health Information. During the course of serving your interests, it may be necessary to share information with other Health Care Providers or Business Associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to consult with a dental laboratory. For payment purposes, we may use a billing service.
- During dental care, we may need to consult with your physician or previous dentist.
- For payment purposes, we may need to supply requested information to your dental insurance company.

We here at Kidiatric Dental are committed to obeying all Federal, State, and local laws and regulations regarding Privacy Practices. If any uses of disclosures, other than the ones listed above, are needed, information will only be released with the written authorization of the individuals in question. The individual, as provided by law, may revoke this written authorization at any time.

By signing below, I agree that I have read and clearly understand all of the above policies.

Signature: _____ Date: _____/_____/_____

Authorization to Use or Disclose Health Information

Patient Name: _____ Date of Birth: _____

Parent/Guardian Name: _____

I. Authorization

You may use or disclose the following health care information (check each that apply):

☐ General Health information maintained by the above-named practice

☐ Health information relating to the following treatment or condition: _____

☐ Health information for the date(s): _____

☐ Other: _____

You may disclose this health information to:

Name (or title) and organization: _____

Address: _____ City: _____ State: _____ Zip _____

Reason(s) for this authorization: _____

This authorization ends: ☐ on (Date) _____

☐ When the following event occurs: _____

II. Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form:

- To receive a copy/copies of my dental records
- To receive health care when the purpose is to create health information for a third party

I may revoke this authorization in writing at any time. If I do, it would not affect any actions already taken by the above-named practice based upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. The form is available from the office.

  or
- Write a letter to the office.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed Name, if signed on behalf of the patient Relationship (parent, legal guardian, personal representative, etc.)

Photo Release Waiver

I _____ authorize Kidiatric Dental & Orthodontics to use my child/children _____ 's photograph publicly for promotions. I understand that the images may be used in print publications, online publications, electronic presentations, and social media. I also understand that no realty, fee, or other compensation shall become payable to me by reason of such use.

Parent/Guardian Name _____
Parent/Guardian Signature: _____ **Date:** _____
☐ **Yes, please tag me on social media @**_____

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