kids first dental

Patient Information

Today's Date: _____ How did you hear about us? _____

Child's Name: _____ DOB: _____ Sex (circle one) M F Age_____

Nickname: _____ Home Phone: _____ Cell # _____

Home Address: _____ City, State Zip:_____

Mailing Address: _____ City, State Zip:_____

Person financially responsible for child: _____ Relationship? _____

Home # _____ Work # _____ Cell # _____

Parent/Guardian Information

Father/Guardian Name:_____

DOB: _____ SS#: _____

Address (if different from above):

_____

Email: _____

Dental Insurance for minor/child

Employer: _____

Ins Co. Name: _____

Group #_____ ID # _____

Ins Phone #: _____

Mother/Guardian Name: _____

DOB: _____ SS#: _____

Address (if different from above):

_____

Email: _____

Dental Insurance for minor/child

Employer: _____

Ins Co Name: _____

Group #_____ ID #_____

Ins Phone #: _____

Is your child eligible for treatment under Medicaid? (circle one) YES NO

State Medicaid ID #: _____

Medical History

(Check all that Apply)

- Abnormal Bleeding
- Alcohol Abuse
- Allergies Type:_____
- Anemia
- Angina Pectoris
- Arthritis
- Artificial Bones
- Artificial Heart Valve
- Asthma
- Blood Transfusion
- Cancer/Chemo
- Colitis
- Congenital Heart Defect
- Cosmetic Surgery
- Diabetes
- Difficulty Breathing
- Drug Abuse
- Emphysema
- Epilepsy
- Fainting Spells
- Fever Blisters
- Frequent Headaches
- Glaucoma
- Hay Fever
- Heart Attack
- Heart Surgery
- Hemophilia
- Hepatitis A
- Hepatitis B
- High Blood Pressure
- HIV
- Kidney Problems
- Liver Disease
- Low Blood Pressure
- Mitral Valve Prolapse
- Pacemaker
- Pneumocytes
- Psychiatric Problems
- Radiation Therapy
- Rheumatic Fever
- Seizures
- Shingles
- Sickle Cell
- Sinus Problems
- Stroke
- Thyroid Problems
- Tuberculosis
- Ulcers
- Venereal Disease
- Jaundice

Please Describe Any Conditions checked above: _____

_____

Minor/Child Physician: _____ Phone # _____

City/State: _____ Date of Last Exam: _____

Hospitalized? Y N Date: _____ Reason: _____

Surgeries? Y N Date: _____ Surgery Type: _____

Current Medications: _____

_____

Medication Allergies? Y N If yes, please list: _____

Dental History

Date of Last Dental Visit: _____ Where: _____

Any injuries to mouth/teeth/head? Yes No If Yes, Describe: _____

Any mouth habits? (Circle any that apply):

Thumb Sucking Nail Biting Mouth Breathing Teeth Grinding Uses Pacifier

Other (Please describe): _____

Any Unhappy Dental Experiences? Yes No

If Yes, Please Describe: _____

Does child brush own teeth daily?	Yes	No
Does child floss own teeth daily?	Yes	No
Does child use home Fluoride Rinse?	Yes	No

The above information is complete and correct to the best of my knowledge.

By signing, I certify that I am the parent/guardian/foster parent or personal representative of the minor/child. I further certify that there are no court orders in effect that prohibit me from signing this consent. I hereby authorize the dental staff to perform necessary dental services for this minor/child. These services include but are not limited to: X-rays, exams, cleaning, fluoride treatments, sealants, etc. whether or not I am present when the treatment is rendered.

Parent/Guardian or Approved HIPPA party MUST be present for any dental treatment that requires the administration of anesthetics or nitrous. **No Exceptions.**

Insurance Assignment and Release: I assign any/all insurance benefits directly to Kids First Dental, LLC for services rendered. I understand that I am financially responsible for ALL charges, regardless of payment by my insurance. I authorize the use of my digital signature on all insurance submissions. Kids First Dental, LLC may use my minor/child's health care information and may disclose such information to the appropriate insurance company for the purpose of obtaining payment for services rendered and/or determining benefits payable for Dr. recommended services.

Acceptance of insurance by this office does not absolve financial responsibility for charges in full for all treatment rendered. Any estimates provided are to be considered a guideline only based on insurance information obtained at time of service. Kids First Dental, LLC can make no guarantee of insurance payments. Please present current insurance information at each time of service.

Kids First Dental, LLC is in network with most commercial insurance companies and will gladly file dental claims to your primary and secondary insurance company as a courtesy. Any portion of fees that are not covered by your primary insurance will be due at time of service. In the event you have secondary coverage, we will file your claim and insurance will directly reimburse the subscriber. Our office DOES NOT retro file or back file dental claims. If insurance information changes, this information must be provided to our office prior to service.

Parent/Guardian Signature: _____ Date: _____

Broken Appointment Policy

We encourage you to keep all scheduled appointments. You MUST give notification with any changes to your scheduled appointment. If you miss/break TWO appointments without notice before the appointment, we will no longer be able to schedule future appointments for your child. If you have confirmed your appointment and do not keep the appointment, we will no longer schedule future appointments. We DO NOT reschedule confirmed treatment appointments that were broken. We ask that if you are unable to keep your reserved appointment to PLEASE contact the office before your scheduled time.

Receipt of Notice of Privacy Practices

Limited Authorization and Release Form

Patient Name: _____ Date: _____

Please list any other parties who are actively involved in your healthcare and who can have access to your health information. (This may include stepparents, grandparents, caretakers, etc. who can have access to patient's records)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this practice. A copy of this signed, dated document shall be as effective as the original. **My signature will also serve as a PHI Document Release should I request treatment plans or x-rays be sent to other Dentist/Practices in the future.**

Please print Name of Patient: _____

Please print Parent/Guardian Name: _____

Signature of Parent/Guardian: _____