

Kids Dental Care Patient Registration

Patient's Name: _____ **Birth Date:** _____ **Sex:** Male Female
Address: _____ **City:** _____ **State:** _____ **Zip:** _____
Home Telephone # _____ **Other #** _____
 Whom may we thank for referring you? _____
 Mother **Guardian** Name: _____ **DOB:** _____ **SS#** _____
 Place of Employment: _____ work # _____
 Home telephone # _____ Cell # _____ Email _____
 Father **Guardian** Name: _____ **DOB:** _____ **SS#** _____
 Place of Employment: _____ work # _____
 Home telephone # _____ Cell # _____ Email _____
 Emergency contact other than parents : _____ (____) _____
Name Phone Relationship

Insurance Information

Name of person Insured: _____ Relationship to patient: _____
 Insured's Social Security # _____ DOB: _____
 Employer: _____ Insurance Co. _____ Telephone # _____
 Group # _____ ID# _____
 Ins. Co. Address: _____ City: _____ State: _____ Zip: _____
Secondary Insurance (If applicable)
 Name of person Insured: _____ Relationship to patient: _____
 Insured's Social Security # _____ DOB: _____
 Employer: _____ Insurance Co. _____ Telephone # _____
 Group # _____ ID# _____
 Ins. Co. Address: _____ City: _____ State: _____ Zip: _____

Dental History

Date of last visit to a dentist _____ For what service _____ _____ Has child complained about dental problems? Yes No _____ Any unhappy dental experiences Yes No _____ Any injuries to mouth ó teeth ó head Yes No _____ Any unusual speech habit Yes No _____ Orthodontic appliances, worn or ever been Yes No Any mouth habits Yes No Thumb sucking Lip biting Mouth breathing Pacifier use Tongue thrusting Mouth odor Jaw pain Biting hard objects	Does your child brush teeth daily? Yes No Do you assist your child for tooth brushing? Yes No How often _____ Is dental floss used? Yes No How often _____ Are disclosing tablets used Yes No _____ Is fluoride taken in any form Yes No _____ Any lost teeth Yes No Have missing teeth been replaced Yes No Child's attitude toward dentistry Yes No Summary (for doctor's use) _____ _____ _____
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Health & Social History

Name: _____	Birth Date: _____	Sex:	<input type="checkbox"/> Male	<input type="checkbox"/> Female
1. Does the patient have any health problems (past or present)?			Yes	No
If yes, explain _____				
2. Is the patient currently seeing a physician for any problem?			Yes	No
If yes, explain _____				
3. Does the patient take any medications?			Yes	No
If yes, list (including dose) _____				
4. Does the patient have an allergy to any food, medicine or materials (e.g. antibiotics, latex)?			Yes	No
If yes, explain _____				
5. Has the patient ever had a heart murmur, heart defect or rheumatic fever?			Yes	No
If yes, explain _____				
6. Has the patient ever been injured, hospitalized or received surgery?			Yes	No
If yes, explain _____				
7. Is the patient pregnant or has been pregnant in the past?			Yes	No
8. Has the patient ever had a blood transfusion?			Yes	No
9. Has the patient ever had any of the following:				
• Breathing problems or asthma?			Yes	No
• Airway, tonsil or adenoid problems?			Yes	No
• Blood problems such as sickle cell anemia?			Yes	No
• Easy bleeding or bruising?			Yes	No
• Seizures, dizziness, fainting spells or epilepsy?			Yes	No
• Frequent headaches?			Yes	No
• Frequent cough or tuberculosis(T.B.)?			Yes	No
• Hepatitis or liver problems?			Yes	No
• Stomach, bowel problems or gastric reflux?			Yes	No
• Diabetes, excessive thirst or urination?			Yes	No
• Other endocrine or hormone problems?			Yes	No
• Kidney problems?			Yes	No
• Hives or skin rash?			Yes	No
• AIDS or HIV infection?			Yes	No
• General anesthesia?			Yes	No
• Birth defect or disability?			Yes	No
10. Does anyone in the immediate family have history of allergies, diabetes, etc.?			Yes	No
If yes, explain _____				
11. Did the patient have any health problems or illnesses when younger or at birth?			Yes	No
If yes, explain _____				
12. Has the patient have any disease, condition or problem not listed above?			Yes	No
If yes, explain _____				
13. Does the patient have emotional, behavior or learning problems (e.g. ADD/ADHD)?			Yes	No
If yes, explain _____				
14. Does the patient fear the pediatrician?			Yes	No
15. Has the patient related well to previous treatments?			Yes	No
16. Name and address of patient's PEDIATRICIAN or family physician: _____				
_____ Date of last physical examination: _____				

To the best of my knowledge, the above information is complete and accurate. Providing incorrect information can be dangerous to my child's health and I will inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered to my child during the period of such dental care to third party payers and/or other health practitioners.

Signature of Parent/ Guardian: _____ **Date:** _____

Financial Policy

INSURANCE: As a courtesy to all patients we will verify your dental insurance benefits, but you are responsible to know your Plan coverage, exclusions and limitations. Furthermore, you should be aware of non-covered benefits such as frequency limits for exams, prophylaxis, fluoride and x-rays etc. The estimated amount not covered by your insurance is due at the time of treatment and may be paid by cash, personal check, to help you accept an extensive treatment plan we are offering an interest free dental treatment Financing Program. All estimates are subject to final approval by your dental insurance plan; therefore the amount due is subject to change after final explanation of benefits have been paid. _____ **(Initials)**

INITIAL PAYMENT FOR DENTAL TREATMENT: Most plans are covered for routine clinical exam and cleaning, no deductible is due for diagnostic or preventative treatment unless otherwise stated. There are some Plans with coinsurance payment for x-rays and dental exam.

RESIN-BASED COMPOSIT RESTORATIONS (Fillings): Most dental insurance plans do not allow full benefits for composites (white fillings) performed on posterior teeth (back molars). The plan benefit will customarily pay for less expensive treatment- AMALGAM (silver/mercury based restoration). For our patients' best interests, we only use composite-based (white) fillings. The difference is usually \$30-\$50 per filling and the patient is responsible for the difference in cost. Please ask our assistants or doctors if you need more information about composite-based white fillings. _____ **(Initials)**

PULP-CAP TREATMENT (medicament to protect pulp chamber): Most dental plans do not allow additional benefits for pulp-cap treatment (this procedure in which the filling is very deep and the nearly exposed pulp is covered with a protective medication to help with healing and repair via formation for secondary dentin). The cost of this treatment is \$20- \$53 per tooth (depends on your Insurance coverage) and the patient is responsible for payment at the time of treatment. If your Insurance does not cover it or does not allow separate benefits, you will be charged a contracted fee (between us as a provider and The Insurance) . _____ **(Initials)**

FINANCIAL CHARGES: All returned checks are subject to \$25 fee. We have the option to report your balance with us to any credit reporting agency and credit bureau. In the event that your account is turned over to a Collection Agency or attorney, you agree to pay all fees including and not limited to attorney fees, court costs, and collection agency fees. _____ **(Initials)**

I understand that payment of a calculated % is due at the time treatment I rendered, and that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on behalf of my dependant(s), including any balance not paid by the dental insurance company within 30 days of the date of service. I understand that I am responsible for handling any disputes regarding amount of payment with the insurance company. I authorize and request my insurance company to pay directly to Kids Dental Care any insurance benefits otherwise payable to me.

I HAVE READ AND UNDERSTAND THE ABOVE INFORMATION; ALL MY QUESTIONS WERE ANSWERED TO MY SATISFACTION; I UNDERSTAND AND AGREE TO ALL POLICIES OF KIDS DENTAL CARE.

Guarantor Name: _____ **Signature:** _____

Patient's Name: _____ **Relationship:** _____

Date: _____ **Time:** _____ **am / pm**

Pediatric Dentistry Consent for Dental Procedures & Acknowledgement of Receipt of Information

It is the policy of this dental practice to inform parents of all procedures contemplated for your child. At each examination appointment we will identify any dental treatment needed and describe this to you and your child. Each regular examination visit consists of oral hygiene instructions, cleaning of the teeth, topical application of fluoride, radiographs (x-rays) if needed, and examination of the teeth, hard and soft tissues of the mouth and the bite. Any other treatment needed such as fillings, caps, extractions, etc. will be performed at a separate appointment after obtaining your permission.

State Law requires that we obtain your written informed consent for any treatment given your child as a legal minor. Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain it further.

1. I hereby authorize and direct Dr. Ammar Idlibi assisted by other dentists and/or dental auxiliaries of his choice, to perform upon my child the following dental treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.
2. In general terms the dental procedures or operation will include:
 - Cleaning of the teeth and the application of topical fluoride.
 - Application of plastic sealants to the grooves of the teeth.
 - Treatment of diseased or injured teeth with dental restoration (filling or caps).
 - Replacement of missing teeth with dental prosthesis.
 - Removal (extraction) of one or more teeth.
 - Treatment of malpositioned (crooked) teeth and/or oral developmental or growth abnormalities.
 - Use of local anesthesia, by injection, to numb the teeth worked on. Numbness usually lasts from 1½ - 3 hours. Allergic reactions are rare. Your child will be cautioned not to bite the numb lip and cheek. Please do not tell your child that they are going to get a shot. We have our special way of informing them of this.
 - Use of Nitrous Oxide (laughing gas). This is used to help children relax and feel the injection less. This gas is placed over your child's nose after an explanation is given. Again, this gas is very safe when used in the concentration that we use. The nose piece, as with all treatment, will not be forced on your child.
 - Use of behavior management techniques as described on the behavior management page.

I fully understand there is a possibility of surgical and/or medical complications developing during or after the procedure. Although rare, these risks and side effects may include adverse reaction to a drug that may cause necessary hospitalization, further surgical procedures, disability, system impairment, permanent or temporary nerve damage, brain damage or death. I further authorize Dr. Ammar Idlibi to perform treatment as may be advisable to preserve the health and life of my child.

I further understand that the parents may be asked remain in the reception area for the duration of their child's visit. However, for the initial visit, the parent will accompany the child to the consultation area. Upon completion of consultation, the parent might be requested to return to the reception area.

I hereby state that I have read and understand this consent and the behavior management techniques and that all questions about the procedure or procedures have been answered in a satisfactory manner; and I understand that I have a right to be provided with answers to questions which may arise during the course of my child's treatment.

I further understand that this consent will remain in effect until such time that I choose to terminate it.

Patient's Name: _____

Signature of Parent or Guardian: _____

Date: _____ **Time:** _____ **am / pm**

Relationship to Patient: _____

Acknowledgement of Receipt of Notice of Privacy Practices

You may refuse to sign this acknowledgement

I, _____ have received a copy of this office's Privacy Practices.

Please Print Name: _____ Signature: _____

Relationship to Patient: _____ Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

Individual refused to sign

Communications barriers prohibited obtaining the acknowledgement

An emergency situation prevented us from obtaining acknowledgement

Other (Please Specify _____)

Kids Dental Care Office Policy for Broken Appointments & Acknowledgement

All appointments are confirmed by phone at the beginning of each day with at least 24 hours notice to the patients.

The confirmation call from our office is a courtesy to our patients. It is NOT mandatory. It is the patients' responsibility to know when their appointment is and to call us with reasonable notice, 24 hours, if it is to be cancelled or changed.

If a 24 hours notice is not given when canceling or rescheduling an appointment, it is considered as a broken appointment and a \$50.00 fee will be charged for any broken appointment. This fee must be collected before the patient can be seen in our office again. Two or more broken appointments will result in deactivating your child's records in our office.

We understand our patients' time is valuable and this is why we schedule appointments, so that the patient can arrange their schedules accordingly.

We appreciate you as our patient and thank you in advance for understanding our policy.

I understand and acknowledge this policy. I also understand that this fee is not covered by my insurance and I will be responsible for any monetary obligation.

Signature of Parent or Guardian: _____ Date: _____

Relationship to Patient: _____