# Kids Dental Care Pediatric Patient Registration

**To be updated every two years**

Patient's Name: _____

DOB: _____ SS# _____ Sex: Male / Female

Address: _____ Apt/Unit/Floor: _____

City: _____ State: _____ Zip Code: _____

Home Phone #: (  ) _____ - _____ Cell Phone #: (  ) _____ - _____

Email Address: _____

Mother/Guardian Name: _____ DOB: _____ SS#: _____

Father/Guardian Name: _____ DOB: _____ SS#: _____

Whom may we thank for referring you: _____

Emergency Contact: _____ _____ (  )_____-_____

Name Relationship Phone

## Insurance Information

### Primary Insurance (If applicable)

Name of the policy holder: _____ Relationship to the patient: _____

Employer of policy holder: _____

Policy holder's Social Security #: _____ Policy Holder's DOB: _____

Insurance Co.: _____ Group #: _____ ID#: _____

### Secondary Insurance (If applicable)

Name of the policy holder: _____ Relationship to the patient: _____

Employer of policy holder: _____

Policy holder's Social Security #: _____ Policy Holder's DOB: _____

Insurance Co.: _____ Group #: _____ ID#: _____

# Dental History

Date of last visit to a dentist: _____ For what service: _____

Does your child brush and floss their teeth daily? Yes or No Frequency: _____

Are they experiencing any dental problems? Yes or No If yes, explain: _____

Any unhappy dental experiences? Yes or No If yes, explain: _____

Any injuries to mouth, teeth, head? Yes or No If yes, explain: _____

Is fluoride taken in any form? Yes or No If yes, explain: _____

Any unusual speech habit? Yes or No If yes, explain: _____

Lost any permanent teeth? Yes or No If yes, explain: _____

Have missing teeth been replaced? Yes or No If yes, explain: _____

Orthodontic appliances worn or ever been worn? Yes or No

Any of the following habits: Summary (for doctor's use) _____

Lip biting Mouth breathing Pacifier use _____

Tongue thrusting Nail biting Mouth odor _____

Jaw pain Biting hard objects _____

## Patient Name: _____

## Health & Social History To be updated every year

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, explain _____
4) Does the patient have any 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 been pregnant in the past? Yes ❑ No ❑
8) Has the patient ever had a blood transfusion? Yes ❑ No ❑

### Has the patient ever had any of the following?

| | | | |
|---|---|---|---|
| Breathing problems or asthma? | Y / N | Airway, tonsil or adenoid problems? | Y / N |
| Blood problems such as sickle cell anemia? | Y / N | Easy bleeding on brushing? | Y / N |
| AIDS or HIV infection? | Y / N | Frequent headaches? | Y / N |
| Frequent cough or tuberculosis (T.B.)? | Y / N | Hepatitis or liver problems? | Y / N |
| Stomach, bowel problems or gastric reflux? | Y / N | Diabetes, excessive thirst or urination? | Y / N |
| Endocrine or hormone problems? | Y / N | Kidney problems? | Y / N |
| Hives or skin rash? | Y / N | Seizures, dizziness, fainting spells or epilepsy? | Y / N |
| General anesthesia? | Y / N | Birth defect or disability? | Y / N |

1) Does the patient have or had any disease or condition not listed above? Yes ❑ No ❑
If yes, explain _____
2) Does anyone in the immediate family have history of allergies, diabetes, etc.? Yes ❑ No ❑
If yes, explain _____
3) Did the patient have any health problems or illnesses when younger or at birth? Yes ❑ No ❑
If yes, explain _____
4) Does the patient have any emotional, behavior or learning problems (e.g. ADD/ADHD)? Yes ❑ No ❑
If yes, explain _____
5) Has the patient related well to previous treatments? Yes ❑ No ❑
If no, explain _____

Name of Patient's Pediatrician: _____ Date of Last Physical: _____

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 during the period of such dental care to third party payers and/or other health practitioners.

Patient's Name: _____ Parent/Guardian's Name: _____

Signature: _____ Date: _____

**For Office Use Only:** **Reviewed By:**

Provider's Name: _____

Signature: _____ Date: _____

# Financial Policy

**INSURANCE:** As a courtesy to all the 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 or 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.

**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 COMPOSITE RESTORATIONS (Fillings):** Most dental insurance plans do not allow full benefit 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 - $90 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.

**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).

**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.

I understand that payment of a calculated % is due at the time treatment is 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 dependent(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.

Patient's Name: _____

Parent/Guardian's Name: _____

Signature: _____ Date: _____

# Consent for Dental Procedure and Acknowledgement of Receipt of Information

It is a 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. 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 to your child. Please read this form carefully and ask us 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 mispositioned (crooked) teeth and/or oral development 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.
    - Use of Nitrous Oxide (laughing gas). This is used to help 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 upon your child.

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 reactions to a drug that may cause necessary hospitalization. I further authorize Dr. Ammar Idlibi to perform treatment as may be advisable to preserve health and life.

I further understand that any family members may be asked to remain in the reception area for the duration of my child's visit. However, for the initial visit, family members may accompany your child to the consultation area. Upon completion of consultation, family members might be requested to return to the reception area.

I hereby state that I have read and understand this consent and that all questions about the 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 treatment.

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

Patient's Name: _____ Parent/Guardian's Name: _____

Signature: _____ Date: _____

# 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.**

**Patient's Name:** _____

**Parent/Guardian's Name:** _____

**Signature:** _____ **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

Other (Please Specify):

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**Paperwork has been reviewed and verified by:**

**Employee's initials:** _____ **Date:** _____

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# IMPORTANT

# Kids Dental Care Appointment Policy

**ARRIVAL ON TIME**

1. You will be pleased to know that we are committed to providing services to our patients on time. You must check in at a time which is appropriate for us to service you on time. We have determined from our experience that it takes about 15 minutes to complete our checking-in procedure which includes going through all your paperwork for accuracy, eligibility, insurance cards, signed consent forms for minors, updating paperwork if necessary, etc. In order for us to service you on time, you need to arrive 15 minutes before the appointment time.

2. Minors must be accompanied by their parents/guardians. Others must produce **OUR** signed third party form. Minors will NOT BE SERVICED without this document.

**LATECOMERS**

3. Those patients who do not arrive 15 minutes before their appointment time WILL NOT BE SERVICED and WILL BE RESCHEDULED. Servicing latecomers seriously interferes with our servicing patients who arrive on time (which is 15 minutes before appointment time) and leads to a domino effect for all the remaining patients.

**RESERVING YOUR APPOINTMENT**

**Your appointment time has been reserved just for you with YOUR consent.**

4. It is the RESPONSIBILITY of patients to call us 2 days before the appointment date to confirm. If you cannot keep this appointment, please let us know that you want to reschedule.

5. If you do not call two days before the appointment date, it may no longer be available to you. Please understand that another patient who called to reserve the appointment will be seen first. We will make an effort to fit you into the schedule OR give you a time you know you can come.

6. Three broken appointments will result in our deactivating your records from our office.

Please remember, our APPOINTMENT POLICY has been established ONLY for your benefit.

You can call us anytime and leave a message.