Patient Registration

Kind Kids DENTAL

TELL US ABOUT YOUR CHILD

Child's Name _____
First Middle Initial Last

Nickname _____ Gender _____

Preferred pronoun she he they

Child's Birthdate ____/____/____ Child's Age _____

Child's Home Address _____

City, State, Zip _____

PARENT #1

Name _____

Relationship to child _____

Address _____

City, State, Zip _____

Primary # _____

Birthdate _____ SSN _____

Email Address _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Do you have legal custody of this child? ☐ Yes ☐ No

Employer _____ Occupation _____

PARENT #2

Name _____

Address _____

City, State, Zip _____

☐ Same as parent #1

Primary # _____

Birthdate _____ SSN _____

Email Address _____

Marital Status ☐ Single ☐ Married ☐ Separated ☐ Widowed ☐ Divorced

Do you have legal custody of this child? ☐ Yes ☐ No

Employer _____ Occupation _____

INDIVIDUALS OTHER THAN LEGAL GUARDIAN AUTHORIZED TO BRING CHILD AND CONSENT FOR TREATMENT Grandparents, etc.

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Signature _____

If treatment involves nitrous oxide, individual must be 18 years or older to bring child.

PRIMARY DENTAL INSURANCE

Insurance Co. Name _____

Insurance Co. Phone _____

Subscriber Member # _____

Group # _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ___/___/___ SSN _____

Policy Owner's Employer _____

SECONDARY DENTAL INSURANCE

Insurance Co. Name _____

Insurance Co. Phone _____

Subscriber Member # _____

Group # _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ___/___/___ SSN _____

Policy Owner's Employer _____

WHERE DID YOU HEAR ABOUT US?

☐ Community event _____ ☐ Internet search

☐ Patient referral _____ ☐ Location/driving by

☐ Other _____

AUTHORIZATION

I certify the truth of all information given. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to the doctors at Kind Kids Dental, otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental insurance. My part of the expenses will be due today or at the time services are rendered.

_____

Signature of Parent/Guardian Print Name Date

Kind Kids DENTAL

PATIENT NAME _____ **DATE OF BIRTH** _____

Main reason for today's visit: _____

If applicable, previous dentist name _____ Date of last visit _____

Reason for leaving _____

DENTAL HISTORY

How often are the child's teeth brushed? ☐ 1x/day ☐ 2x/day ☐ Every Other Day ☐ Not Regularly

How often are the child's teeth being flossed? ☐ 1x/day ☐ 2x/day ☐ Every Other Day ☐ Not Regularly

Who does the brushing and flossing? ☐ Parent ☐ Child ☐ Half/Half ☐ None

Fluoride Use? ☐ Rx by MD/DMD ☐ in H2O ☐ Toothpaste ☐ Rinse ☐ None

Does your child have any oral habits? ☐ Thumb/Finger ☐ Binky ☐ Mouth Breather ☐ Grinding ☐ None

History of Dental Trauma? If yes, please explain: _____

How would you rate mother's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ I don't know

How would you rate father's oral health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor ☐ I don't know

How would you rate your child's sugar consumption? (candy, juice, etc.) ☐ Low ☐ Average ☐ High

When was your child weaned off nursing/bottle? ☐ 6 Months ☐ 12 Months ☐ 24 Months ☐ Still Use ☐ I don't know

MEDICAL HISTORY

Is your child under a physician's care other than his/her PCP? ☐ Yes ☐ No If yes, explain _____

Has your child ever been hospitalized or had any surgeries? ☐ Yes ☐ No If yes, explain (list dates) _____

Has your child ever had any serious complications from general anesthesia? ☐ Yes ☐ No If yes, explain _____

Has your child ever had a serious head injury? ☐ Yes ☐ No If yes, explain _____

DOES YOUR CHILD HAVE ANY ALLERGIES?

☐ None ☐ Aspirin ☐ Penicillin/Amoxicillin ☐ Codeine
☐ Acrylic ☐ Augmentin ☐ Clindamycin ☐ Metal
☐ Latex ☐ Sulfa drugs ☐ Local anesthesia ☐ Zithromax
☐ Other _____

IS YOUR CHILD TAKING ANY MEDICATIONS?

Please list all medications your child is currently taking: ☐ None

_____

_____

DOES YOUR CHILD HAVE ANY OF THE FOLLOWING?

Yes	No		Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	ADD/ADHD	☐	☐	Cerebral Palsy	☐	☐	Frequent Headaches	☐	☐	Kidney Problems	☐	☐	Shingles
☐	☐	AIDS/HIV Positive	☐	☐	Chemotherapy	☐	☐	Glaucoma	☐	☐	Leukemia	☐	☐	Sinus Trouble
☐	☐	Anaphylaxis	☐	☐	Chest Pains	☐	☐	Hay Fever	☐	☐	Liver Disease	☐	☐	Special Diet
☐	☐	Anemia	☐	☐	Cold Sores/Fever Blisters	☐	☐	Hearing Loss	☐	☐	Lung Disease	☐	☐	Speech Therapy
☐	☐	Artificial Heart Valve	☐	☐	Congenital Heart Disorder	☐	☐	Heart Murmur	☐	☐	Mitral Valve Prolapse	☐	☐	Spina Bifida
☐	☐	Asthma	☐	☐	Diabetes	☐	☐	Heart Trouble/Disease	☐	☐	Pain in Jaw Joints	☐	☐	Thyroid Disease
☐	☐	Autism	☐	☐	Epilepsy or Seizures	☐	☐	Hemophilia	☐	☐	Psychiatric Care	☐	☐	Tonsilitis
☐	☐	Blood Disease	☐	☐	Excessive Bleeding	☐	☐	Hepatitis Type	☐	☐	Radiation Treatments	☐	☐	Tuberculosis
☐	☐	Blood Transfusion	☐	☐	Fainting Spells/Dizziness	☐	☐	Herpes	☐	☐	Recent Weight Loss	☐	☐	Vision Problems
☐	☐	Breathing Problems	☐	☐	Food Allergies	☐	☐	Hives or Rash	☐	☐	Renal Dialysis	☐	☐	Yellow Jaundice
☐	☐	Bruise Easily	☐	☐	Frequent Cough	☐	☐	Intestinal Disease	☐	☐	Rheumatic Fever			
☐	☐	Cancer	☐	☐	Frequent Diarrhea	☐	☐	Irregular Heartbeat	☐	☐	Scarlet Fever			

Has your child ever had any other serious conditions not listed above? Yes No If yes, _____

If yes to heart murmur, does your child need a pre-medication for dental treatment? Yes No If yes, _____

Does your child have a genetic disorder? Yes No If yes, _____

Does your child have a syndrome/disease? Yes No If yes, _____

Child's physician: Name _____ Phone _____ Last appt? _____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to my child's health. It is my responsibility to inform Kind Kids Dental of any changes in my child's medical status.

_____

Signature of Parent/Guardian (or Patient if 18yo+) Date

Kind Kids DENTAL

PATIENT NAME _____ **DATE OF BIRTH** _____

Please initial that you have read and understand each section.

_____ Financial Policy

I have received the Kind Kids Dental Financial and Insurance Policy that outlines my financial responsibility toward care rendered by the doctors at Kind Kids Dental. I understand that the parent or legal guardian who accompanies my child to an appointment will be responsible for payment at the time services are rendered.

_____ Appointment Cancellation or No-Show Policy

I take full responsibility for the cancellation/rescheduling of any needed appointments. A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, WE REQUIRE AT LEAST A 24 HOUR NOTICE PRIOR TO YOUR APPOINTMENT TIME to avoid a $40 cancellation fee. Many patients are waiting months in advance for appointments, please respect our schedule and our other patients by giving us time to fill your reserved spot with another patient in need of care. Should a patient fail to keep a surgery appointment a $200 fee will be charged if advance notice is not given so that appointment may be given to another child in need of treatment. Should no advance notice of cancellation be given, Kind Kids Dental reserves the right to dismiss the patient from the practice after 3 missed or late cancelled appointments.

_____ Medical/Dental Release Statements

As the birth/adoptive parent or legal guardian, I give my consent for the doctors of Kind Kids Dental to complete a thorough examination on the patient named above including any needed diagnostic radiographs. To the best of my knowledge the information I have provided is accurate and I understand that it will be held in the strictest of confidence and in accordance to all federal and state HIPAA regulations. Further more, I understand that it is my responsibility to inform Kind Kids Dental of any future changes to my child's medical history status. As a parent or legal guardian of the previously named patient, I also hereby grant the doctors and staff of Kind Kids Dental permission to perform future treatment(s) as deemed appropriate. I understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time services are rendered, unless prior arrangements have been approved.

_____ Insurance Claim Release & Financial Responsibility Statement

To precipitate the filing of this and all future dental insurance claims, I do hereby authorize the release of confidential information to my child's dental insurance company. I am aware that Kind Kids Dental will be providing an estimate of the insurance coverage prior to initiating any future treatment and that I am legally responsible for any portions not paid by this policy. I understand that additional out-of-pocket expenses may be accrued should estimates provided by my insurance company be inaccurate or should procedures change during the course of the treatment. Furthermore, I am aware of my financial responsibility should my insurance policy fail to pay, for any reason, within 45 days of receiving such treatment.

_____ Authorization for Direct Payment

I hereby authorize payment of insurance benefits directly to Kind Kids Dental or the dentist that performs treatment on my child. Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount.

_____ Notice of Privacy Practices, Health Insurance Portability & Accountability Act of 1996

I have read the form entitled, "Notice of Privacy Practices," and understand its contents concerning the privacy of my child's confidential healthcare information. I do hereby provide consent for the standard use of such information and understand that these provisions prohibit Kind Kids Dental from selling or transferring this information to any unauthorized locations without my prior approval. I have reviewed this information and all questions have been answered to my satisfaction.

I have read and understand the above policies.

Signature of Parent/Guardian Date

Photo Release

Kind Kids Dental has my permission to use my child's photograph to promote the dental practice. I understand that the images may be used in print, online publications, website, social media, etc. I understand that no royalty, fee or other compensation will be payable to me for using the images.

☐ I DO NO WANT MY CHILD'S IMAGES USED

Signature of Parent/Guardian Date

Financial Policy and Insurance Information

Kind Kids DENTAL

Methods of Payment

For your convenience we accept cash, check and credit cards (Visa, MasterCard).

As we strive to be one of the area's leading providers for pediatric dental care, we work to assist parents in taking an active role in their child's dental health. Because we value our relationship with you and believe that the best relationships are based upon understanding, we offer these clarifications on methods of payment & insurance reimbursement.

Please contact Kind Kids Dental immediately after making any changes to your dental coverage, so we can keep our records current and to provide expeditious reimbursement of your benefits.

If any treatment needs are discovered during your child's exam, we will provide you with a cost estimate indicating our total fee, what we anticipate your insurance coverage to be, and your ESTIMATED out-of-pocket portion for the treatment plan. We will discuss all treatment options and costs before beginning any further treatment. We know that dental insurance can be confusing so feel free to contact us with insurance or payment questions.

Dental Insurance

We are dedicated to providing all our patients with the best treatment available and base all our treatment recommendations on what will be best for your child and not what your insurance company does or doesn't pay. Please note the following in regards to your dental insurance coverage:

1. We must emphasize that as a health care provider, our relationship is with you and not your dental insurance company. Your dental insurance is a contract between you, your employer and the insurance company. Most plans routinely pay between 50-75% of the average total fee for a given procedure. This percentage is pre-determined by the plan your employer has purchased.

2. As a courtesy, we will be happy to file for your insurance benefits. Because your dental insurance plan is a contract between you, your employer, and the insurance company, many carriers will not reimburse our office. In this instance, you will be responsible for the full cost of each visit at the time services are provided and your insurance company will send you the reimbursement check directly.

3. Any amount not covered by your insurance company 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 may not be covered by your specific dental insurance. Our primary goal is to treat your child using the best possible materials, supplies, medications and environment.

4. We allow a maximum of 45 days for your insurance company to clear account balances. Any unpaid portions will be due in full, by you, after this period. If you have not paid your balance within 60 days of the date treatment was rendered, a finance charge of 1.5% will be added to your account each month until paid. Should your insurance company submit payment after this time, we will be glad to reimburse you. This is rare but is important that you recognize that your insurance is a legal contract between you and your insurance company. Our office is not, and cannot be part of that legal contract. Ultimately you are responsible for all charges incurred in our office.

5. Our office does not determine your dental benefits. Your employer chooses your particular policy. If you are unhappy with it's coverage, this should be mentioned to your employer's benefits coordinator. Only your employer can adjust benefits.

Prior to completing any treatment, we will provide you with a cost estimate indicating our total fee, what we anticipate your insurance coverage to be, and your estimated out-of-pocket portion (estimated patient portion or EPP). Please remember, this is only an estimate based upon generalized information provided by your dental insurance company. An additional billing or possibly a refund may be subsequently required should information provided be inaccurate.

We will always do our best to maximize the insurance benefits that you are eligible to receive and we appreciate your prompt settlement of any charges that may be incurred during the treatment process. We look forward to years of close association with you, as we work together to maintain your child's oral health!