KAO PEDIATRIC DENTISTRY

PATIENT INFORMATION

Child's Full Name: _____ Goes by: _____ ○ Male ○ Female
Date of birth: _____ Age: _____
Address: _____ City/State: _____ Zip Code: _____
Phone Number: ( ) _____ ○ Home ○ Mobile
Current School: _____ Grade: _____
Hobbies/Interest: _____
Please List Any Other Siblings Seen in Our Office:
_____
Whom Should We Thank for Referring You? _____

PARENT/LEGAL GUARDIAN (LG) INFORMATION

Parent/LG Name: _____ Relation to Patient: _____
Date of Birth: _____ SSN: _____ Address: ○Same As Above ○
Different (If Different, Please Indicate Alternative address)_____
City/State: _____ Zip Code: _____
Best Contact Number: ( )_____ ○Home ○ Mobile ○ Work
Employer: _____ Work Number: ( ) _____
Primary E-Mail: _____

Parent/LG Name: _____ Relation to Patient: _____
Date of Birth: _____ SSN: _____ Address: ○Same As Above ○
Different (If Different, Please Indicate Alternative address)_____
City/State: _____ Zip Code: _____
Best Contact Number: ( )_____ ○Home ○ Mobile ○ Work
Employer: _____ Work Number: ( ) _____
Primary E-Mail: _____

DENTAL INSURANCE

1. Policy Holder: _____ Insurance Company: _____
SSN: _____ DOB: _____ Group Number: _____

2. Policy Holder: _____ Insurance Company: _____
SSN: _____ DOB: _____ Group Number: _____

DENTAL HISTORY

○Y ○N Is This Your Child's First Visit to the Dentist?
If Not, When Was Their Last Visit?
_____

○Y ○N Were X-Rays Taken?

○Y ○N Has Your Child Ever Had a Bad Experience?

○Y ○N Did Your Child Nurse or Use the Bottle After 12 months?

○Y ○N Did /Does Your Child Nurse or Use a Bottle During the Night?

○Y ○N Do You Assist Your Child's brushing

How Often Do They Brush _____
Floss_____

○Y ○N Does Your Child Have Any Habits? (Thumb Sucking, Pacifier, etc.) _____

○Y ○N Does Your Child Drink Juice or Soda?
If So, How Much a Day? _____

○Y ○N Does Your Child Snack Frequently Throughout the Day?

○Y ○N Has Your Child Had a Toothache or Any Type of Oral Pain Recently?

○Y ○N Has Your Child Ever Had a Dental Injury? (Bumped, Chipped, Bruised etc.)
Explain: _____

Type of Water Source: ○City Water ○ System ○ Private Well ○ Filtered/Bottled Water

Purpose of Today's Visit: _____

TO THE BEST OF MY KNOWLEDGE, THE ANSWERS I HAVE GIVEN ARE ACCURATE. I UNDERSTAND THAT IT IS IMPORTANT TO REPORT CHANGES IN MY CHILD'S MEDICAL OR DENTAL STATUS TO THE DENTIST, AND I AGREE TO DO SO. I GIVE PERMISSION TO THE DENTIST TO OBTAIN ADDITIONAL INFORMATION FROM MY CHILD'S PHYSICIAN REGUARDING MEDICAL HISTORY NEEDED TO PROVIED DENTAL TREATMENT.

PARENT/ LG SIGNATURE: _____ DATE:_____

EMERGENCY CONTACT INFORMATION (other than parents)

Contact Name: _____ Relationship to Patient: _____
Phone Number: ( ) _____ ○Home ○ Mobile
Contact Name: _____ Relationship to Patient: _____
Phone Number: ( ) _____ ○Home ○ Mobile

Child's Name _____ DOB_____

MEDICAL HISTORY

Physician / Phone Number: _____
Is Your Child Current on Their Immunizations? ○ Yes ○ No
Please list any medications that your child is taking: _____
Please list any allergies your child has (including medications): _____

○Y ○N ADD/ADHD	○Y ○N Anemia	○Y ○N Anxiety/Depression
○Y ○N Asthma	○Y ○N Autism/Asperger's	○Y ○N Cerebral Palsy
○Y ○N Chronic Sinusitis	○Y ○N Deaf/Blind	○Y ○N Developmental Delays
○Y ○N Diabetes	○Y ○N Down Syndrome	○Y ○N Epilepsy/Seizures
○Y ○N Fainting	○Y ○N Heart Problem	○Y ○N Heart Murmur
○Y ○N HIV/AIDS	○Y ○N Kidney/Bladder Disease	○Y ○N Liver Disease/Hepatitis
○Y ○N Malignancies	○Y ○N Rheumatoid Arthritis	○Y ○N Sensory Issues
○Y ○N Speech Delay	○Y ○N Thyroid Problem	○Y ○N Tuberculosis

Please List Any Surgeries or Hospitalizations: _____

Additional Medical Information: _____

Date:_____ Parent/Guardian Signature_____

Updated_____ Parent/Guardian Signature_____

Updated_____ Parent/Guardian Signature_____

FINANCIAL POLICY

PLEASE READ AND INITIAL THE ITEMS BLOW AND SIGN THE BOTTOM OF THE FORM

PREPAYMENT COURTESY: We are happy to off a 5% courtesy discount for treatment over $150 that is **PAID IN FULL** with cash, check, or credit card prior to the reserved time of service. This discount cannot be combined with any other discounts (i.e. office gift cards).

INITIAL _____

PAYMENT AS SERVICES ARE RENDERED: Your co-pay is **due** at the time the services are rendered. Because your insurance company makes no guarantee of payment, we can only estimate your insurance coverage. For this reason, you may receive a statement with an additional balance after your insurance has met their obligation. We ask that your portion be paid at the of service or within fifteen (15) days of receiving such statement. Our office also realizes that some families are within a state of change and on occasion question who is responsible for the bill. Ultimately, the parent who request dental services will be responsible for the fees incurred.

INITIAL _____

OUTSTANDING BALANCES: We do not wish to cause any further financial burdens to families with balances. It is our policy that any outstanding co-pays be paid in full. A finance charge will be assessed and appear on your statement once your account is deemed delinquent. Delinquent accounts over ninety **(90) days** with failure to remain in contact with our office will be turned over to our collections agency – which may adversely affect your credit rating.

INITIAL _____

FOLLOW-UP DENTAL CARE: No healthcare provider can provide guarantees regarding treatment success. We feel that to increase your child's chances of long term success, we recommend that you follow up with regular check-ups every 3 or 6 months, complete proposed treatment, brush and floss twice a day, and encourage a proper diet. In doing this, you are giving your child the best possible opportunity to achieve long-term oral health.

INITIAL _____

IN-OFFICE ACCEPTED FORMS OF PAYMENT:

All major credit cards	Cash	Check	Health Savings Account (HAS) or Flex spending	CareCredit 6 month terms

Parent/ Legal Guardian Signature _____ Date: _____

APPOINTMENT CANCELLATION POLICY

PLEASE READ AND INITIAL THE ITEMS BLOW AND SIGN THE BOTTOM OF THE FORM

Our team works hard to render excellent dental care to all of our children. In an effort to be consistent with this, we have an Appointment Cancellation Policy that allows us to schedule appointments for all of our children in a timely manner. When an appointment is scheduled, that date and time has been specifically reserved for you. When it is missed, we cannot use this time to see other child.

OUR POLICY IS AS FOLLOWS:

We require that you give notice to our office forty-eight (48) **business hours** prior to the appointment in the event you need to reschedule your child's appointment. This allows us to give an opportunity to see another child in that scheduled time frame.

INITIAL _____

If you miss an appointment without contacting our office within the required time, this is considered a missed appointment and a $25.00 rescheduling fee will be charged to you – This fee cannot be billed to your insurance company and will be your direct responsibility.

INITIAL _____

If a patient is more than **fifteen (15) minutes late** without prior notice for a scheduled appointment, we will consider this a missed appointment and the $25.00 rescheduling fee will be charged.

INITIAL _____

If you have any questions regarding this policy, please let one of our team members in the front desk know and we will gladly clarify any questions that you may have.

I have read and understand the Appointment Cancellation Policy for Kao Pediatric Dentistry. I agree to be bound by the terms. I also understand that such terms may be amended from time to time by the office. If you would like a copy of our Appointment Cancellation Policy, please ask one of our team members at the front desk to make a copy for you.

Parent/ Legal Guardian Signature _____ Date: _____

INFORMED CONSENT FOR *ROUTINE* DENTAL PROCEDURES

As the patient's parent/ legal guardian you have the right to accept or reject dental treatment recommended by the dentists at Kao Pediatric Dentistry. Prior to consenting to treatment, you should carefully consider the anticipated benefits, and commonly known risks of the recommended procedure, alternative treatment, and the option of no treatment.

Do not consent to treatment unless and until you discuss potential benefits, risk, and complications with your child's dentist we want to make sure all your concerns are addressed. By consenting to the treatment, you are acknowledging your willingness to accept risks and complication, no matter how slight the probability of occurrence.

It is very important that you provide the doctor with accurate information before, during, and after treatment. It is equally important that you follow our doctor's advice and recommendations regarding medication, pre-and post op treatment instructions, referrals to other dentist or specialist, and return for scheduled appointments. If you fail to follow their advice, you may increase the chances of a poor outcome.

Please read and initial the items below and sign the bottom of the form.

1. **TREATMENT TO BE PROVIDED:** I understand that during my child's course of treatment the following may be provided: Examinations, preventative services (fluoride, sealants, and space maintainers), restorations (fillings), crowns and radiographs (x-rays). I will be consulted prior to each to appointment.

   Initial _____

2. **DRUGS AND MEDICATIONS:** I understand that antibiotics, analgesia, anesthetic agents and other medications may cause allergic reactions causing redness and swelling of tissues, pain, itching, vomiting, and or anaphylactic shock (severe allergic reaction).

   Initial _____

3. **CHANGES IN TREATMENT PLAN:** I understand that during treatment it may be necessary to change or add procedures because of the conditions found while working on the teeth that were not discovered during examination. The most common changes are root canal therapy and extraction, following routine restorative procedures. I give my permission to my child's dentist to make any/all changes and additions as necessary. I understand that I will be consulted regarding changes whenever possible.

   Initial _____

Parent/ Legal Guardian Signature _____ Date: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENTS

I understand that under Health Insurance Portability & Accountability Act of 1996 (HIPPA), I have certain rights to privacy regarding my child's protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my child's treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly or indirectly.

2. Obtain Payments from third-party payers.

3. Conduct normal healthcare operations such as quality assessments and physician certifications.

I acknowledge that I have received the Notice of Privacy Practices containing a more complete description of uses and disclosures of my child's health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request, in writing, that the office may restrict how your child's private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand the dental office is not required to agree to my requested restrictions; However, if you agree, that you are bound by such restrictions. I understand that I have the right to revoke this consent except to the extent that we have already acted covered under this consent.

If I choose to revoke that consent, I must do so in writing.

Contact information:
Child's name: _____ Date of Birth: _____

May we contact you at: ○Home ○Work ○Mobile

Please list persons with whom we may discuss your child's health care information:
_____
Please list persons we may release medical information, including picking up prescriptions: ○ Same as above
_____
Please list persons who we are **NOT** allowed to release any information to: _____

If necessary, may we contact your child's pediatrician? ○Yes ○No

Parent/Legal Guardian Signature _____ Date: _____