

Patient Health History

Patient Name _____ Birth date: _____ Today's Date: _____

Child's Physician _____

Emergency Contact besides parents (name and cell number) _____

DENTAL HISTORY:

Date of Last Dental Visit: _____ Previous Dentist: _____

Has your child ever had dental work? _____ If yes, how did the visit(s) go? _____

How do you expect your child to do for their visit today? _____

MEDICAL HISTORY:

Please list ANY diagnosis your child has ever been given, or any that you or a provider have/do suspect.

SURGERIES/EMERGENCIES:

Has your child EVER had any surgery, hospitalization or visited the emergency room. If yes, please give a brief explanation.

MEDICATIONS AND MEDICATION HISTORY:

Please list any medications, including vitamins, herbs or supplements your child takes now or has taken in the past.

ALLERGIES OR SUSPECTED ALLERGIES:

Please tell us about any drug, food, dye or other allergies your child has or you suspect:

RELEVANT SOCIAL HISTORY:

Is there any other situations in your child's home life, such as shared custody, recent stressors, or other things that you think we should know about to help us better care for your child?

Please allow us to thank whoever recommended us. A recommendation is our highest compliment and we want to show our gratitude. Who told you about us or how did you hear about our office???



At Kidstown Dental we are excited to be a part of Pediatric Dentistry in this day and time! Where going to the dentist as a child used to be “just looking for cavities” and deciding when it is “time to do braces.” Today, we can do so much more to prevent both cavities and orthodontics!! While this is great, what is even better is that if we do our job well, we can screen children easily for issues that not only affect their oral health, but also their overall health! And, if we identify some of these issues early, we can make simple suggestions that will have a huge impact on your child’s life! So, toward that end, please answer the following questions:

Sleep

1. Does your child seem well rested when it is time to get up in the morning? _____
2. Does your child snore? _____
3. Does your child grind their teeth at night? _____
4. Does your child have night terrors? _____
5. Does your child wet the bed? _____
6. Does your child sleep still or do they move like a “tornado” in the sheets? _____
7. Do you have any concerns about your child’s sleep? _____

School/Social

1. Does your child have good social interactions and peer relationships? _____
2. Does your child have good reports on behavior in school? _____
3. Does your child find it easy to sit and focus in school and with homework? _____
4. Do you have any concerns about your child’s school or social interactions? _____

Eating

1. Is your child a particularly messy eater? _____
2. Does your child chew with their mouth open? _____
3. Does your child resist certain textured foods or gag often when eating? _____
4. Do you have any concerns with how or what your child eats? _____

Speaking

1. Is it easy for others to understand your child when they speak? _____
2. Does your child have challenges with certain letters or sounds? _____
3. Do you have any concerns regarding your child’s speech? _____



Our Appointment Policy:

An appointment in ur schedule is a bond of trust that we will be here to serve you and you will be present for treatment. We strive to create a schedule that most efficiently provides for the dental needs of all of the patients we serve.

Please arrive on-time to your scheduled appointment. Late arrivals cause schedule delays for those patients who arrive promptly at their appointment time. Late arrivals will be worked into the schedule if time allows or re-appointed to another day. Our office policy is firm in this regard.

Our cancellation policy:

We ask that you make every effort to give us at least a 24 hour notice if you cannot make your scheduled appointment. It is our policy to charge any patient for a broken appointment.

When you give us 24 hour notice, your reserved time can be made available for another patient.

When patients do not show for their appointment or do not give us adequate cancellation notice, we are not given the opportunity to reschedule that time with another patient who has a true dental need.

Cancellations:

Additionally, while we understand that things may come up, it's very important that we receive notice of a change in plans at least 24 hours in advance. Please view our practice cancellation policy below for more details.

We respect our patients' time and make every effort to remain on schedule. Some visits are more complicated than initially anticipated, and emergencies may arise that could delay us. If we are significantly delayed, every effort will be made to notify you beforehand so you may choose to come later or reschedule. If you are going to be late, we ask that you please notify us. If you are significantly delayed, your scheduled treatment may be modified or you may be asked to reschedule your appointment.

Because of the level of service we provide our patients, your appointment is especially held just for you, so that we have the right amount of time for your procedure at our office.

Thank you for your understanding the value of our cancellation policy to each of our patients.

Signature of Responsible Party: _____ Date: _____

Demographic & Insurance Information:

The information requested on this form will be entered into our secured computer database. The security level of our patient information is equivalent to the security banks use for online storage and management of financial data. It will be used for contacting your family regarding appointments or other communications related to your care in our office. In addition, as a courtesy, it will be used for filling your insurance claim electronically. This paper will be shredded after the information is put into our database.

Please circle your preferred method of contact: TEXT / EMAIL / PHONE

Mother's Name: _____ Contact #: _____

Father's Name: _____ Contact #: _____

Home Address: _____ City: _____ Zip: _____

Email Address: _____

If your child has dental insurance coverage, and you want us to file, we will need the information at the beginning of the visit or a few minutes before to verify the insurance. If it is well into the visit before you are able to give us the ID or SSN or the parent who carries the insurance, and there is a problem with coverage, or for some other reason we cannot verify, you will need to pay in full and receive help filling it after the visit: Thank you for your understanding!

Insurance Company: _____ Phone #: _____

Policy Holder's Name: _____ Date of Birth: _____

Policy Holder's Social Security Number and or ID number: _____

Group Number: _____

Policy Holder's Employer: _____

Signature: _____ Date: _____

Kidstown Dental First Visit Consent

Patient (s) Name: _____

Today's Date: _____

We want to thank you for bringing your child to Kidstown Dental. We hope that your experience here makes you happy that you chose our office for your child's dental home.

The purpose of this document is to inform you of treatments commonly performed here at Kidstown Dental on a child's first visit. Each of the treatments mentioned below, if risks, benefits and alternatives will be discussed with you and your child. If you know in advance there are one or more of these procedures that you do not want for your child, please do not sign next to that line, and let us know right away your reason for not wanting that treatment so we can document it in your child's record. Please feel free to ask questions at any time regarding any treatment recommended here at our office. We value your questions and your trust.

- _____ Examination
- _____ Cleaning/Prophylaxis (including scaling or polishing)
- _____ Fluoride application
- _____ X-rays (as needed for age, development, and risk of oral diseases)
- _____ On "theme days", special occasions, and for children with "Smile awards" we love to take photographs. We post photographs on Friday to our Facebook page to share with the community a little bit about our office. We never put names on the photographs. If you are comfortable with your child's photograph being taken and posted to Facebook, please initial.
- _____ Sealants (occasionally able to do same day if needed.)

The signature below this paragraph is to be signed at your first appointment. Your signature on the line below means several important things that we want to be sure of before we begin. One, that you have read this entire form and have understand it. Two, that when you initial or sign above, next to a treatment, you are signifying, or saying that you understand and agree to that treatment for your child.

Thank you again for your trust in us and for making Kidstown Dental your child's dental home!

Your name and relationship to Child: _____

Signature: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I received a copy of this office's Notice of Privacy Practices.

Please print your name here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

The patient refused to sign.

- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other (*Please provide specific details*)

Employee Signature

Date



Dental Insurance:

At Kidstown Dental we accept all PPO dental plans. We are not in contract with any insurance plan, therefore we are not considered "in network". We cannot accept DMO/HMO plans as a specialist office.

After your appointment, we will submit your claim to your insurance company for you. If you have a deductible or a co-pay due for services provided, those fees are due at the time of service. We do our best to provide you with a complete estimate before any treatment is done, and we make every effort to maximize your dental benefits. However, each employer designs their own dental plan. To completely understand what is covered by your dental benefit plan, it is best to contact your employer or insurance company as they will give you more detailed information than they will give us.

For services not fully covered or not submitted to insurance, we accept carecredit, cash, check and all major credit cards. We do ask for payment at the time of service. If a balance is due after the insurance is submitted, you will receive a statement requesting payment for the balance owed.

Financing:

Kidstown Dental accepts Carecredit, which offers you the flexibility of monthly payments. Visit www.carecredit.com for more information and to apply.



Pediatric X-Rays

Our commitment to your child

We want your child to have the best possible experience at our dental office and to love coming to the dentist for all of their lives. The most common reasons people hate going to the dentist is because they remember gagging with x-rays and feeling numb after an injection.

Since we opened in 2012, we have promoted a no-gag x-ray procedure and a laser “no shot” filling procedure. We consider this a compassionate and ethical way to treat children. Many of our patients actually come to our office for this reason. The standard type of x-ray is called a bitewing x-ray. Some children with very small mouths or with very strong gag reflexes find this type of x-ray painful. If a bitewing x-ray is not possible for your child we will use a different x-ray technique– a periapical view. This still gives us the information we need to look for cavities but anyone can tolerate it without pain or gagging.

Our commitment to you

We want to help you maximize whatever insurance coverage your employer(s) has provided. Your coverage is determined by what plan your employer has chosen as a benefit and by the policies of that particular plan.

In the past all x-rays (bitewings and periapical) were covered as diagnostic and preventative by all insurance companies (which they are by definition diagnostic and preventative). As such they were covered by insurance before a deductible was required. **Recently many insurance companies have changed their policy regarding reimbursement of x-rays.** Some have changed their coding of periapical x-rays to a basic service– those that require you meet a deductible first and then they only pay a percentage of the fee.

We are very disappointed about this new barrier that insurance companies have put in the way of the families. We will always attempt to get the bitewing view first. If your child cannot tolerate a bitewing x-ray we will not force them, even though it may mean a small out of pocket expense to you.

We hope you understand that we always put your child first.

Dental insurance’s job is to give you bargain care. It is our job to give you the best care.

Signature: _____ **Date:** _____