Date____________

Confidential Patient Information

+ A B C -

Patient's Name____
Last First Middle Nickname Gender

Address____
Street City State Zip

Home Phone______________________ Birthdate__________________ Social Security #__________________

If patient is a minor, give parent's or guardian's name_______________________________

Whom may we thank for referring you to our office?_______________________________

Confidential Responsible Party Information

Name_______________________________________ Marital Status_________
Last First Middle

Residence____
Street City State Zip

Mailing Address____
Street City State Zip

How long at this address_____________ Home Phone______________________ Work Phone________________

Cell Phone _____________________________ Email _______________________________

Previous Address (if less than 3 yrs.)_______________________________________
Street City State Zip

Social Security #___________________ Birthdate__________________ Relationship to Patient______________

Employer_________________________ Occupation________________ No. Years Employed_______________

Spouse's Name_______________________________________ Rel. to Patient______________
Last First Middle

Employer_________________________ Occupation________________ No. Years Employed_______________

Social Security #___________________ Birthdate__________________ Work Phone______________________

Insurance Information

Policy Holder's Name____ and Member ID #__________________

Insurance Company______________________________ Group No.___________ Birthdate__________________

Insurance Co. Address____ Insurance Co. Phone_______________

Policy Holder's Employer____

Do you have dual coverage? No ☐ Yes ☐ If yes:

Policy Holder's Name____ and Soc. Sec. #____________________

Insurance Company______________________________ Group No.___________ Birthdate__________________

Insurance Co. Address____ Insurance Co. Phone_______________

Policy Holder's Employer____

Emergency Information

Name of nearest relative not living with you____

Complete Address____

Phone____________________________ Relationship:____________________________________

I understand that where appropriate, credit bureau reports may be obtained.

Signature (Parent's signature if minor)____

Updates (date & initial)____

CONFIDENTIAL (for record and pretreatment evaluation)

© Zuelke & Associates, Inc. 0601

Patient______________________ Date of Birth_______________

Confidential Patient Medical History

Physician's Name__________________________Phone_________________________Last Visit_____________

Has patient ever been under the extended care of a physician or had any surgeries? Yes ☐ No ☐

If yes, Please explain:

CHECK ANY OF THE FOLLOWING FOR WHICH THE PATIENT HAS BEEN TREATED

☐ Heart Conditions (murmur, etc)
☐ Excessive Bleeding
☐ Diabetes
☐ Rheumatic Fever
☐ Liver Problems
☐ Cancer
☐ Hearing Loss
☐ HIV Positive
☐ Tuberculosis
☐ Asthma
☐ Epilepsy
☐ Birth Defects
☐ Infections
☐ Hepatitis
☐ Frequent Headaches
☐ Kidney Infections
☐ Cerebral Palsy
☐ Eyesight Problems
☐ Speech Impairments

Is your child currently on any medications? Yes ☐ No ☐
Is your child allergic to any foods or medicines? Yes ☐ No ☐
Is your child subject to any nervous disorders such as autism, ADHD, or any other mental illness? Yes ☐ No ☐

Confidential Patient Dental History

Does your child currently floss? Yes ☐ No ☐
When does your child brush their teeth?
☐ Upon rising in morning ☐ After eating any food ☐ After meals ☐ Before going to bed
How does your child currently receive fluoride?
☐ Community Water, ppm_ ☐ Well Water, ppm___ ☐ Drops or Tablets ☐ Rinse or Gels
Please describe your child's diet (regular/favorite foods): ____

____

**To help connect with child please tell us about your child's interest (favorite sports, hobbies, TV shows, movies, etc:

____

Thank You for taking the time to fill out!

I certify that the above information is complete and accurate.

Parent/Guardian Signature___________________________________ Date_________________
Dentist Signature____ Date_________________

Your Name: ___________________________________ **Today's Date:** __________________________

Relationship to Patient(s):___________________ **Patient(s) Name:** ________________________

____

____

How would you like us to communicate with you?

Our dental office sends appointment reminders, information about treatment, payment and insurance, and other communications including but not limited to newsletters, events, etc. Please tell us how you would like us to communicate with you.

Check or complete all that apply (please print clearly):

☐ Contact me by U.S. Mail at the following address: _____________________________________

☐ Contact me by email at the following email address: __________________________________

For Phone and Text Communications:

This form is optional. You are not required to sign this form, and you do not need to sign it to receive care in our dental office.

Phone Number: ____

☐ **By checking this box, I consent to the following:** The dental practice or its service provider may contact me to provide health care information such as appointment reminders and information about treatment, payment, my account or insurance, using artificial or prerecorded voice or telephone equipment that may be capable of automatic dialing. The dental practice may:

- ☐ Call me
- ☐ Text me
- ☐ Call me and text me

Signature: ____Date: ________________

Please call Dentistry for Kids right away if you get a new telephone number!

For Office Use Only:

☐ Consent revoked. Date/Initials: ________/________

☐ Possible reassigned number. Date/Initials: ________/________

☐ Confirmed accurate.

Date/Initials: ________/________ Date/Initials: _______/________

Date/Initials: ________/________ Date/Initials: _______/________

Date/Initials: ________/________ Date/Initials: _______/________

Insurance and Financial Policy

Our commitment at Dentistry for Kids is to provide the best quality dental care possible to your child. This same commitment to your child's oral health is not always shared by every insurance company or by the employer who has purchased the dental benefits on your behalf. Consequently, some preventative and most restorative services prescribed for your child are seldom covered by your insurance company at 100%. Should there be a gap between the cost of the quality dental care provided to your child by DFK and the amount your insurance company reimburses, the difference will be your responsibility. At your request, we will do all we can to help you understand and maximize the benefits available to you through your insurance provider, but ultimately it is your responsibility to understand the coverage of your policy prior to care being provided and charges incurred. In addition, should you request that basic preventative care or necessary treatment (as outlined by the American Academy of Pediatric Dentistry) not be performed on your child based on the limitations of your insurance benefit, Dentistry for Kids may decide not to take on the personal liability of foregoing these important steps to achieve the patients optimal oral health and comfort.
INITIAL ______

Our Mission: *"Quality Care and a Positive Patient Experience"*

The Doctors and staff at Dentistry for Kids have an unwavering commitment to your child's superior oral health. We use sound scientific and ethical principles, as outlined by the AAPD, in order to provide your child with the highest standard of pediatric dental care available in our area. We also recognize that creating a fun, friendly and comfortable environment is critical to the child's long-term oral health. We know you have a choice in dental providers and we hope that these goals are the primary reasons you have chosen our practice. Please keep in mind that all of the following policies center on accomplishing these two core philosophies.

Please make sure that we have the most current insurance information before each appointment, if applicable, contact information and your preference on the method of contact.
(please see Communication Consent Form)

I (We) have read, understand, and agree to Dentistry for Kids appointment and communication approach.

Family Account # ________________ Date: ________________

______________________________ ______________________________
Parent/Guardian name - relationship Parent/Guardian name-relationship

______________________________ ______________________________
Parent/Guardian's Signature Parent/Guardian's Signature

Appointment Policy

We ask for a two business day notice on all cancelled or rescheduled appointments. This allows us to fill your child's scheduled time with another child who may be in need of more urgent dental care. *An appointment cancelled in less than 48 hours, or an appointment missed completely without notice, may not be rescheduled for up to 6-8 weeks and* a *charge of $35 may be incurred. In rare cases where no shows or less than 48 cancellations persists it could lead to the end of the doctor/patient relationship.* We understand that emergencies happen and in those rare situations we will do all that we can to accommodate your special needs. INITIAL ____

We please ask that all parents make a special effort to be at their child's appointment on time in order to allow us to provide a quality experience for each child. If a patient is late to an appointment they may be required to reschedule. *However, in* a *situation where there is space in the schedule we will try to fit your child in, provided we can still make it* a *positive experience for your child.* INITIAL ____

Our Communication Approach

Our top priority is to give you all the information needed to make informed decisions in regards to your child's oral health. This includes providing you with the nature of recommended procedures, the risks of those procedures, any alternatives to the procedures recommended and an *estimate* of the costs involved to perform those procedures. We hope that open communication is important to you as well and that any concerns you have about treatment or our policies will be brought immediately to our attention with the same courtesy and respect.

Please make sure that we have the most current Insurance information before each appointment, if applicable, contact information and your preference on the method of contact.
(please see Communication Consent Form)

I (We) have read, understand, and agree to Dentistry for Kids appointment and communication approach.

Family Account # ___________________ Date: ___________________

______________________________ ______________________________
Parent/Guardian name - relationship Parent/Guardian name-relationship

______________________________ ______________________________
Parent/Guardian's Signature Parent/Guardian's Signature

Dear Dentistry for Kids families:

We are updating our Financial, Appointment and Communication procedures at DFK. For your convenience, please go to our website at www.dentistrvforkidsreno.com to submit these forms online if you would like to complete them before your child's next appointment at DFK. We will also have them available in the office to fill out at the next appointment. We are asking all responsible parties/parents to sign the documents either living in the same or separate households so that all parties are aware of the procedures.

To help our families with busy schedules we are sending you several reminders to be able to confirm the appointment or reschedule without incurring our less than ***48 hour cancelation fee of*** *$35* ***per appointment:***

- When the appointment is booked you will receive an email save the date.
- A second email will be sent two weeks prior to the appointment as a reminder.
- We will send you a text and email one week before the appointment with a reminder of our cancelation fee.
- There will be another text two days before at which you can still confirm via text response.
- You will receive a last minute reminder text two hours before the appointment.

Please verify your email address and the phone number you would like to have these confirmations sent to is correct in the family account for both parents. Our system will allow one email and one phone number to be sent these reminders.

Feel free to contact us with any questions that you may have regarding the above documents or appointment policies. We will also follow up during your next visit at DFK if we do not have them on file. You can print the documents and email the signed copies back to us at info@dentistryforkidsreno.com if you would prefer instead of submitting electronically.

Thank you from the Dentistry for Kids Team

AUTHORIZATION FOR MINOR CHILD ACCOMPANY

Child(ren)'s full name (s):____

DOB (s):_______________, ________________, _________________, _________________

I, _________________________________ give ___________________________________

(Parent or Legal Guardian) (Authorized Person's Full Name)

permission to accompany my child(ren) to the office of **Dentistry for Kids** dental appointments.

I also give permission to __________________________________ to make necessary decisions

(Authorized Person's Full Name)

regarding dental treatment for my child(ren) including, but not limited to:

- This consent for the authorized person to accompany and sign informed consent(s) for my child(ren)'s for exams, dental cleanings, x-rays and fluoride treatment and to discuss post-operative instructions.
- This consent of **Dentistry for Kids** gives permission to the authorized person to discuss finances treatment charges, account balances and next visit charges.
- This consent for this authorized person to discuss my child(ren)'s dental findings, future dental treatment needs and any pertinent personal health information (PHI).

As the parent or legal guardian, I understand that I must sign any treatment plans and/or informed consents before any restorative procedures or invasive dental treatment can be performed for my child(ren). I further understand that it is my responsibility to provide payment or a source of payment on the day that services are rendered, even when this authorized person brings the child, or no treatment will be performed for my child.

____

(Signature of Parent or Legal Guardian) (Date)

____

(Dentistry for Kids Representative) (Date)