Providing dentistry for toddlers, children, teens and those with special needs in a 'child-friendly' environment

Today's Date: _____

1. Tell Us About Your Child

Child's Name: _____ Middle Initial: _____Goes by: _____ Male / Female

SSN: _____ Child's Birth date: _____/_____/_____ Age: _____

Home Address**:** _____City_____State_____Zip_____

Primary number for appointment confirmations: (_____) _____

Parent/Guardians e-mail address: _____

Other family members seen by us: _____

2. Person Accompanying The Child

A parent or guardian must accompany the child to this visit. The parent or guardian who accompanies the child is responsible for payment at the time of service.

Name: _____Relation to child: _____

Address: _____

Phone**:** (_____) _____ Work #: (_____) _____Ext:_____ Cell #: (_____) _____

Are you the legal guardian of this child? Yes / No Are you the person responsible for the account? Yes / No

If no, please name the legal guardian / responsible party:_____

How did you hear about us? _____ Whom may we thank for referring you:_____

3. Parent's Information

Marital Status: Married Single Divorced Separated Widowed

Mother Step Mother Legal Guardian

Name: _____ Birth date: _____/_____/_____ SSN: _____

Phone: (_____) _____ Wk# :(_____) _____Cell:_____

Employer: _____ DL#: _____State: _____ Expiration: _____

Father Step Father Legal Guardian

Name: _____ Birth date: _____/_____/_____ SSN: _____

Phone: (_____) _____ Wk# :(_____) _____Cell:_____

Employer: _____ DL#: _____State: _____ Expiration: _____

Who does the patient live with? _____

Emergency Contact (other than parent) – in the event of an emergency, whom should we contact?

Name:_____ Phone #: (_____)_____ Relationship: _____

4. Child's Medical History

Child's physician: _____Phone #: (____)_____ Last Visit: _____

Has your child ever had the following medical problems?

□ ADD	□ Cerebral Palsy	□ Nervous Disorder	□ Rheumatic Fever
□ ADHD	□ Diabetes	□ HIV	□ Seasonal Allergy
□ AIDS	□ Downs Syndrome	□ Kidney Problem	□ Seizure
□ Asthma	□ Emotional Disorder	□ Liver Problem	□ Sickle Cell Anemia
□ Autism	□ Epilepsy	□ Leukemia	□ Speech Disorder
□ Blood Disorder	□ Hearing Disorder	□ Mental Disorder	□ Tuberculosis
□ Brain Disorder	□ Heart Condition	□ Physical Disability	□ Vision Disorder
□ Cancer	□ Hepatitis	□ Respiratory Problem	□ Other _____

Has your child ever been told that they must be pre-medicated before dental work due to a heart condition? Y N

If Yes, a signed form from the child's cardiologist must be provided explaining the child's condition and amount and type of pre-med needed. No dental treatment will be completed without this form on file.

Is your child in good health? Y/N If no, explain _____

May we have permission to consult with your child's physician: Y/N If no, explain _____

Is the child under care of a physician now? Y/N If yes, explain _____

Has child/minor ever been hospitalized? Y/N Had surgery? Y/N If yes, reason and date _____

Please list any drugs your child is currently taking: _____

Please list any drugs / materials that your child is allergic to: penicillin latex anesthetics codeine metals red dye

Other: _____

5. Child's Dental History

Reason your child is here today:_____

Is this your child's first dental visit? Yes/No

Child's Previous Dentist:_____ Address: _____ Phone #: _____

Date of last visit to a dentist: _____ X-rays taken ? Yes/No Does your child have a toothache? Yes/No

Any history or trauma to teeth or jaws? Yes/No If so, explain_____

Any unhappy medical/dental experiences? Yes/No If so, explain _____

Is/Was your child a finger sucker, lip or nail biter? Yes/No Does/Did your child use a bottle? Yes/No Age quit _____

Does/Did your child use a pacifier? Yes/No Does/Did your child use a sippy cup? Yes/No Age quit _____

Is there any additional information that may help us in caring for your child or any specific concerns you have regarding your child's dental health? _____

The information that I have given is correct to the best of my knowledge. I understand that it will be held on the strictest of confidence, and it is ***my responsibility*** to inform the office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my minor/child, such as dental exams, treatment, and dental x-rays.

Signed (parent/guardian)_____ Date _____

Printed Name _____ Relationship to patient_____

Appointment Policies

We *try* to confirm all appointments, so please make sure we have your correct phone numbers. If you are unable to keep your appointment, we request that you give us at least 24 hours notice so that someone else may use your time.
Due to other patients in the practice we request that you be prompt and on time. If you are late it may be necessary to reschedule your appointment to a later date.

I have read and agree to all the policies above. Please Initial _____

Financial Information

Please read the following:

We accept cash, checks, Debit cards, Visa, and MasterCard, Discover, American Express.

Patient's portion of payment is due at the time of service. We will gladly submit your insurance claim for you; however, we do require any deductibles, co-payments, and "estimated" patient portions be paid at the time of service.
Balances over 90 days will be turned over to a collection agency; In this event**, you will be responsible for all collection and legal fees.**

If a check is returned NSF, there will be a $**25.00 check return fee;** from that point on, checks will not be accepted. Our office reserves the right to charge for appointments cancelled or broken without 24-hour notice.

Insurance Information

Dental Insurance: _____ Policy # _____ Group #_____

Ins. Address:_____

Policy Holder's name: _____ Birthdate: _____/_____/_____ SS#:_____

Policy Holder's employer:_____ Relationship to Patient: _____

Secondary Insurance (if applicable)

Dental Insurance: _____ Policy # _____ Group #_____

Ins. Address:_____

Policy Holder's name: _____ Birthdate: _____/_____/_____ SS#:_____

Policy Holder's employer:_____ Relationship to Patient: _____

Authorization and Release

I authorize Jenni Burkitt DDS PLLC to submit insurance claims on my behalf. I agree to be responsible for payment of all services rendered on behalf of my dependent. I understand that my dental insurance plan is designed to only **share** in my dental costs, usually covering **50 to 80%** of the total dental bill. I understand the amount of dental benefits I receive is determined by my employer or my insurance company, **not by us.** I understand some dental services may **not** be covered by my insurance plan. I understand it is my responsibility to review my insurance policy and to understand my specific dental benefits. In the event my insurance company has not paid their portion within 60 days, the **balance of the bill will become my responsibility.** I understand that if my account is turned over to a collection agency I will be responsible for all collection and legal fees.

I have read and agree to the payment information and release listed above.

_____ _____

Signature of parent or guardian Date

OVER

HIPAA Consent Agreement **(Privacy Act)** * you may refuse to sign this agreement*

I understand that I have certain rights to privacy regarding my protected health insurance portability and accountability act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected heath information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (i.e. my insurance company)
- The day to day healthcare operation of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing, at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Signed this _____ day of _____, 20__.

Print Patient Name_____

Relationship to Patient_____

Signature_____

Office Use Only

I attempted to obtain the patients signature in acknowledgment on this Notice of Privacy Practices Acknowledgment, but was unable to do so as documented below:

Date: _____ Reason: _____ Initials: _____