PATIENT INFORMATION FORM
PEDIATRIC AND ADOLESCENT PATIENTS

The information requested below is very important. Please make it as complete and accurate as possible because it will help us provide the best possible health care service. This information becomes part of our permanent records and will be held in strictest confidence. For parents of children, complete the form for your child.

PERSONAL

Date: _____

1. Name of the patient _____ Age _____
   Nickname or preferred name (if any) _____ Sex _____
   Date of Birth _____ Place of birth _____
   Home Address: Street _____ City _____
   State _____ Zip _____ Telephone No. _____

2. Are there any other children in the family? Yes ☐ No ☐
   Please give names, sex and ages: _____
   _____

3. Name of father (legal guardian) _____ Social Security No. _____
   Employed by _____ City _____ State _____
   Present Position _____ How long held? _____ Business Phone _____
   Home Address (If different from patient's): Street _____
   City _____ State _____ Zip _____ Home Phone _____

4. Name of mother (legal guardian) _____ Social Security No. _____
   Employed by _____ City _____ State _____
   Present Position _____ How long held? _____ Business Phone _____
   Home Address (If different from patient's): Street _____
   City _____ State _____ Zip _____ Home Phone _____

5. Please check the preferred method of payment: Cash ☐ Check ☐ Mastercard/Visa ☐ Dental Insurance ☐

   Dental Insurance
   Name of Insurance Carrier _____
   Name of employer holding policy _____
   Address: Street _____ City _____
   State _____ Zip _____ Telephone _____
   Name of employee _____ Policy No. _____

DENTAL

1. Please check the reason(s) for seeking dental care:

   ☐ Routine Checkup ☐ Toothache ☐ Bleeding around the teeth
   ☐ Appearance of teeth ☐ Swelling of face ☐ Crowding of teeth
   ☐ Accident to teeth ☐ Other (Specify) _____

2. Has the child or adolescent ever been to the dentist? Yes ☐ No ☐ If yes, was it: A specialist or family dentist

3. When did your child or adolescent last receive dental care? _____

4. Have you been pleased with the child's or adolescent's previous dental care? Yes ☐ No ☐ If No, comment:
   _____

5. Has the child or adolescent had any unfavorable experience in a dental or medical office? If yes, please describe:
   _____

6. How do you think your child will react to dental treatment? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
   Comment _____

7. Does your child brush his or her own teeth? Yes ☐ No ☐
   How frequently? _____

8. Do you brush your child's teeth? Yes ☐ No ☐ How frequently? _____
9. Does your child or adolescent use dental floss? Yes ☐ No ☐
10. Do you help the child use dental floss? Yes ☐ No ☐
11. Does the child often have between meal snacks? Yes ☐ No ☐
12. Have the teeth of the child or adolescent ever been injured? Yes ☐ No ☐
13. What was the cause of the accident? _____

How old was the patient? _____ Which teeth were involved? _____

14. Does the child or adolescent currently have any of the following habits? Yes ☐ No ☐ There are no oral habits

☐ Lip sucking ☐ Thumb or finger sucking ☐ Lip biting
☐ Nail biting ☐ Tongue thrusting ☐ Constant mouth breathing

Comment _____

MEDICAL

1. Name of patient's physician _____ Telephone _____
2. Physician's address _____
3. Does the child or adolescent have regular medical examinations? Yes ☐ No ☐ Date of exam _____
4. Were there any difficulties during the pregnancy, delivery or the first year of the child's life? Yes ☐ No ☐
5. If so, Was the child premature? Yes ☐ No ☐ _____
6. Has the child or adolescent been hospitalized since birth? Yes ☐ No ☐ At what age(s) for what reason(s)?
7. _____
8. Is a physician treating the child or adolescent at this time? Yes ☐ No ☐ If yes, for what ? _____
9. Is the child or adolescent taking any medicine at this time? Yes ☐ No ☐

Check what kind: ☐ Antibiotics ☐ Anticoagulants ☐ Anticonvulsants
☐ Cortisone ☐ Other ☐ Tranquilizers

10. Does the child or adolescent have any history of allergies? Yes ☐ No ☐ If so, what? _____

Describe the reaction: _____

11. Has the child or adolescent had an unfavorable reaction to the following drugs? Please check: Yes ☐ No ☐

☐ General Anesthetics ☐ Nitrous Oxide Gas ☐ Aspirin
☐ Local anesthetics ☐ Tranquilizers ☐ Other antibiotics _____
☐ Penicillin ☐ Sedatives
☐ Other medicines _____

12. Has the patient had immunizations for tetanus (DPT, DT)? Yes ☐ No ☐

Indicate approximate date of immunization or last booster? _____

13. Does the patient have a history with any of the following? Please check which one(s):

☐ Hearing difficulties
☐ Speech difficulties
☐ Emotional difficulties
☐ Fainting or dizziness
☐ Poor vision
☐ Liver disease
☐ Diabetes
☐ Bleeding problems
☐ Asthma or wheezing
☐ Rheumatic fever
☐ Kidney disease
☐ Tuberculosis
☐ Skin problems _____
☐ Bone & Joint problems
☐ Epilepsy or seizures
☐ Cerebral palsy
☐ Disease(s) affecting normal growth _____
☐ Anemia
☐ Birth defects _____
☐ Heart problems
☐ Sickle cell anemia
☐ There is NO history of any of these problems.

_____ _____ _____
Signature Relationship to child Date

My Kids' Dentists Treatment Consent

I authorize My Kids' Dentists to examine, clean, and provide any necessary dental treatment for:

_____ _____

Patient's Name **Date**

1) I authorize the use of digital radiographs as may be considered necessary to diagnose and/or treat my child's dental needs. I further authorize the use of anesthetics as may be necessary to treat the dental problem(s). I understand there are possible complications/risks associated with **Nitrous Oxide (laughing gas)** that may include, but are not limited to a tingling sensation or a feeling of heaviness, laughter or giddiness, a floating sensation or a feeling of nausea, vomiting or agitation.

2) I understand that during the course of the patient's dental treatment, something unexpected may arise that may necessitate procedures in addition to or different from those listed on the signed Treatment Plan and that I will be consulted prior to initiation or treatment procedures not on the list and asked to sign a new Treatment Plan. I am aware that the practice of dentistry is not an exact science and acknowledge that NO guarantees have been made to me concerning the results of the dental treatment.

3) I understand that dental treatment for children include efforts to guide their behavior by helping them understand the treatment in terms appropriate to their age. We will provide an environment designed to aid children to learn to cooperate during treatment using a variety of techniques including praise, explanation and demonstration of procedures and instruments (tell, show, do), and variable voice control if deemed necessary.

4) I understand that should the patient become uncooperative during dental procedures with movement of the head, arms and/or legs, this creates a situation in which dental treatment cannot be safely provided. During such disruptive behavior which could cause harm to the patient or the dentist and/or assistant, it may be necessary for the assistant to hold the patient's hands, stabilize the head and/or control leg movements. I further understand that should the patient continue to be combative or uncooperative during dental treatment with excessive body movements, the patient may need to be wrapped in a **papoose** to prevent injury and enable the dentist to safely provide the necessary treatment. Should the use of the papoose be necessary to complete treatment, I will be consulted **prior** to the use and be asked to sign a form providing consent.

5) I understand that I may revoke this consent to treatment at any time and that no further action based on this consent will be initiated.

_____ _____

Print Name of Consenting Parent/Guardian **Signature of Consenting Parent/Guardian**

_____ _____

Witness (Staff) **Date**

My Kids' Dentists 205 Hawkins Store Rd, Suite 100 Kennesaw, GA 30144 770-926-3400

HIPAA – Acknowledgment of Receipt of Notice of Privacy Practices

As of April 2003, the Health Information Portability and Accountability Act (HIPPA) took effect and we want you to know that we take this seriously. Our office is HIPAA compliant when handling your private health information. We may at times be required to electronically submit your information related to insurance claims or in association with treatment in conjunction with another healthcare provider or interested party. Our record systems are secure and we make every effort to monitor and protect the distribution of any of your sensitive private health information. We will not, without your consent, share any private health information with others. We may use or disclose health information about you when contacting you to remind you of a dental appointment or to discuss finances. We may contact you by using a letter, voicemail, text or e-mail. To see the complete HIPAA compliance statement, see our front desk.

Consent of Health Information

In the event that I, _____, cannot accompany my child to their dental visit I give consent for the following individuals to accompany them. Additionally, I give consent for the listed individuals to sign for any scheduled treatment.

1.
2.
3.

I understand that if any of the above information changes, it is my responsibility to notify the staff of My Kids' Dentists.

**Note: If your child is sixteen (16) years of age or older and will be attending their appointment alone or any person(s) not listed above will be accompanying them, please send a signed note allowing for consent.*

**Any child under the age of eighteen (18) MUST be accompanied for any treatment appointments. This does not include cleanings and exams.*

Acknowledgement

I acknowledge that I have read and understand the above information. I hereby authorize My Kids' Dentists to release any medical information required for payment or insurance claims review. I understand and agree with above statements.

_____ _____

Parent/Guardian Signature Date

My Kids' Dentists Financial Policies

Thank you for choosing our practice for your child's dental care. We are committed to their successful treatment. Please understand that payment of your bill is considered a part of your child's treatment. We ask that you review and understand the following details of My Kids' Dentists financial policy and your responsibilities.

- Please be aware that the parent/legal guardian or relative bringing the child to My Kids' Dentists is legally responsible for payment of charges. Statements cannot be sent to other persons. Pre-payment of the appointment is acceptable if the person bringing the child is not the responsible party.
- Payment is expected in full on the day of your child's appointment. For your convenience we accept cash, VISA, MasterCard, American Express, and Discover. We also offer financing through Care Credit.

My Kids' Dentists accepts all PPO Insurances and will file claims on your behalf. Please be aware there is no direct relationship between our practice and your insurance company. The plan chosen by you, and/or your employer determines your dental benefits. As such, we have no control over the terms of your contract, the methods of reimbursement, or the determination of your insurance benefits. We accept assignment of benefits from your insurance company; however, you are responsible for any amount that is not paid by your insurance company.

- We will file your claim electronically as a courtesy, but if your insurance company does not pay us directly, you are responsible for the entire balance and the insurance company will send payments directly to you.

A Courtesy for You

Although some offices refuse to file insurance claims electronically for their patients because of the high cost of doing so, it is our pleasure to extend this courtesy to you. When we file insurance claims, please be aware that this requires a significant amount of time and expense on the part of our staff. Be aware that it takes one full business day to verify your benefits. Additionally, it is imperative that we are informed of any insurance policy or employment changes at a minimum of forty-eight (48) business hours prior to the appointment.

- Please note, any out of pocket expenses paid at the time of service are just an estimate. We work diligently prior to your visit to create the best estimate based on the history of past insurance payments. However, there may be an account balance or a credit due to you following your appointment. Refund checks are issued on a monthly basis.
- Our office will happily share any estimated out of pocket expenses with you when confirming your appointment. This information cannot be left on a voicemail due to privacy policies. It is your responsibility to contact our office to confirm your appointment if you wish to receive any financial information.
- My Kids' Dentists requires that all outstanding balances be paid in full within thirty (30) days. If we have not received payment or you have not contacted us for possible payment arrangements, further action may be taken with a collection agency or small claims court.
- In the event that your account becomes more than thirty (30) days past due a monthly finance charge of $5.00 will be assessed to your account, as well as a $60.00 fee if a collection agency becomes necessary.

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My Kids' Dentists Financial Policies

Broken and Missed Appointments

- We kindly request that when our staff reaches out to remind you of your child's appointment through a call, message, text, or email, if you are unable to be reached, that you contact our office as soon as possible to confirm this appointment. Our office reserves the right to remove your child from the schedule should we not be able to confirm your reserved appointment time.
- If your appointment is broken or missed without a forty-eight (48) business hour notice, My Kids' Dentists may assess a $50.00 broken appointment fee per child if you have multiple children with appointments.
- Our office offers a fifteen (15) minute grace period for all appointments. If you arrive after that grace period our office will attempt to accommodate your child's appointment. In the event we are unable to work your child back into our schedule, we reserve the right to assess a $50.00 broken appointment fee.
- All broken appointment fees must be paid prior to scheduling a new appointment.

Acknowledgement

I acknowledge that I have read and understand the above information. I acknowledge that I am financially responsible for all costs of treatment, including any balance unpaid by insurance within thirty (30) days. I acknowledge that I have read and understand all policies relating to insurance benefits, broken appointments as well as unpaid balances.

_____ _____

Printed Name of Parent/Guardian **Relationship to Patient**

_____ _____

Signature of Parent/Guardian **Date Signed**

_____

_____

_____ _____

Witness (Staff) **Date Signed**