Young KIDZ dental

Welcome

We are pleased to welcome you and your child to our practice. Our goal is to educate, motivate, and promote good oral health that will last a lifetime. Please take a few minutes to fill out this form completely. Please mark "SAME" or "N/A" where appropriate.

1. Tell Us About Your Child

Child's Name: _____Nickname: _____ Male / Female

Home Address: _____

Phone: (_____) _____SSN: _____ Child's Birthdate: _____/_____/_____ Age: _____

School: _____ Grade: _____ Special interests/ Pets:_____

2. Person Accompanying The Child

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

Name: _____ Birthdate: _____/_____/_____ SSN: _____

Phone: (_____) _____ Wk# :(_____) _____Email:_____

Employer: _____Occupation: _____ DL#: _____

Father

Name: _____ Birthdate: _____/_____/_____ SSN: _____

Phone: (_____) _____ Wk# :(_____) _____Email:_____

Employer: _____Occupation: _____ DL#: _____

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4. Child's Dental History

Why did you bring your child to the dentist today? _____

Is your child having dental problems at this time? If so, explain_____

Has your child had any unfavorable dental experiences? If so, explain_____

Date of last dental visit: _____ Previous dentist's name: _____

Is your child's drinking water fluoridated? Yes / No Is your child taking fluoride supplements? Yes / No

How often do your child's teeth get brushed? _____ How often do they get flossed? _____

Does your child have any of the following dental habits? Please circle Y or N

Y N Thumb/ finger sucking	Y N Nursing/ bottle habits	Y N Bites/ chews objects	Y N Mouth breather
Y N Pacifier	Y N Grinds/ clenches teeth	Y N Tongue thrusting	Y N Pain in jaw (TMJ)

5. Child's Medical History

Has your child ever had the following medical problems? Please circle Y or N

Y N **Asthma**	Y N Behavioral problems	Y N Diabetes	Y N HIV / AIDS
Y N **Heart Murmurs**	Y N Cancer	Y N Hepatitis	Y N Nervous disorders
Y N Abnormal Bleeding	Y N Congenital Heart Defect	Y N Handicaps/ Disability	Y N Rheumatic Fever
Y N ADD/ ADHD	Y N Convulsions / Epilepsy	Y N Hearing Impairments	Y N Speech delays
Y N Any hospital stays	Y N Develop./ Learning delays	Y N Hemophilia	Y N Tuberculosis (TB)

Please discuss any medical problems that your child has had:

_____

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

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

Other: _____

6. Consent for Treatment

I attest that the information that I have given is accurate to the best of my knowledge. It is my responsibility to inform this office of any changes in my child's health or other information. I request and authorize Dr. Young, assisted by his dental staff, to examine, clean, apply fluoride, obtain diagnostic radiographs, and provide treatment for my child's teeth. I understand that Dr. Young and his staff might use behavior management techniques such as praise, child appropriate language, demonstration of procedures and instruments, and variable voice tone to aid in cooperation during dental treatment.

_____ _____

Signature of parent or guardian Date

7. Payment Information

Please read the following:

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.

We accept cash, checks, Debit cards, Visa, and MasterCard.

Unpaid balances over 60 days will accrue a **monthly fee** equal to 18% APR. 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. A **missed appointment charge** of $50.00 might be applied to your account if less than 24 hour notice is given.

8. Insurance Information

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

Insurance Name: _____ Ins. Phone: (_____) _____

Ins. Address:_____

Policy ID#: _____Group #:_____Policy Holder's Employer: _____

Secondary Insurance (if applicable)

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

Insurance Name: _____ Ins. Phone: (_____) _____

Ins. Address:_____

Policy ID#: _____Group #: _____Policy Holder's Employer: _____

9. Authorization and Release

I authorize Young Kidz Dental 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 have read and agree to the payment information and release listed above.

_____ _____

Signature of parent or guardian Date

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

I give consent for the Use and Disclosure of Health Information of myself or my dependant for the purposes of Treatment, Payment, or Communication between other healthcare professionals**.**

I understand and have been provided with a copy of this office's ***Notice of Privacy Practices*** that provides a more complete description of health information uses and disclosures.

I understand that I have the right to review a copy of this office's ***Notice of Privacy Practices*** prior to signing this condensed form.

_____
Please Print Name

_____
Signature of parent or guardian

_____
Date

THANK YOU

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but acknowledgement could not be obtained because:

_____ Individual refused to sign _____ Communication barriers prohibited obtaining acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgment _____ Other _____

_____

Insurance Name: _____ Calendar Year?: Y / N_____ Date Verified:_____

Insurance Contact: _____Phone:_____ Eff Date: _____

Deductible:% _____/_____(Child/ Family) Cleaning Sched: _____ FL: _____BW: _____

Preventive: _____% Ded Applies? Y / N Basic: _____% Major: _____% Yrly Max: _____

Sealants: _____ Post. Comp?: Y / N _____% Pano / Full Mouth: _____

Sp Maint: _____% SSC's: _____% Pulps: _____% Nitrous: Y / N _____%

Sedation: Y / N _____% GA: Y / N _____% EC Filing: Y / N Verified Address?: Y / N

Ortho: _____ LT Max: _____

_____

_____