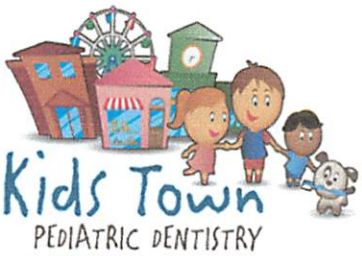

New Patient Form

Today's Date:

NOTE: The parent or guardian who accompanies the child is responsible for payment at the time of service.

1 TELL US ABOUT YOUR CHILD

Child's Name: _____
Last First Middle

Goes by: _____ ☐ Male ☐ Female

Siblings that we treat: _____

Child's Birthdate: ____/____/____ Child's Age: _____

Child's Home #: (____)_____

Child's Home Address: _____

_____
City State Zip

2 MOTHER'S INFORMATION

Name: _____

Mother Stepmother Guardian Birthdate: ____/____/____

Address: _____

_____
City State Zip

Employer: _____

Work #: (____)_____

Home #: (____)_____

Cell #: (____)_____

SSN: _____ DL#: _____

Email Address: _____

3 FATHER'S INFORMATION

Name: _____

Father Stepfather Guardian Birthdate: ____/____/____

Address: _____

_____
City State Zip

Employer: _____

Work #: (____)_____

Home #: (____)_____

Cell #: (____)_____

SSN: _____ DL#: _____

Email Address: _____

4 HOW DID YOU HEAR ABOUT OUR OFFICE?

_____

5 WHO IS ACCOMPANYING YOUR CHILD TODAY?

Name: _____

Relationship: _____

Do you have legal custody of this child? ☐ YES ☐ NO

6 PERSON RESPONSIBLE FOR ACCOUNT

Name: _____

Relationship: _____

Billing Address: _____

_____
City State Zip

Work #: (____)_____

Home #: (____)_____

Cell #: (____)_____

Email Address: _____

7 PRIMARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Phone #: (____) _____

Subscriber or Policy #: _____

Subscriber Name: _____

Relationship to Patient: _____

Subscriber's Birthdate: ____/____/____

SSN: _____

Group Name: _____ Group # _____

8 SECONDARY DENTAL INSURANCE

Insurance Co. Name: _____

Insurance Co. Address: _____

_____
City State Zip

Insurance Phone #: (____) _____

Subscriber or Policy # _____

Subscriber Name: _____

Relationship to Patient: _____

Subscriber's Birthdate: ____/____/____

SSN: _____

Group Name: _____ Group # _____

9 MEDICAL INSURANCE

Insurance Co. Name:_____

Insurance Co. Address:_____

City:_____ State:_____ Zip:_____

Insurance Phone #: _____

Policy or Subscriber ID #:_____

Subscriber Name: _____

Subscriber D.O.B: ____/____/____ / Subscriber SS #_____

Group Name: _____ / Group #: _____

10 Emergency Contact Information

Emergency Contact:

Name: _____

Phone # _____

Relationship to Patient:_____

11

Please be aware that the Insurance you provide to us is a contract between you and your Insurance carrier. YOU are responsible for knowing your Insurance benefits including Maximums, Deductibles, Co-Insurance and Co-pays. We will submit your Insurance and do what is within our power to help you receive your Insurance benefits for the procedures we provide. However, if the Insurance does not pay for specific procedures you understand that it will be YOUR responsibility to pay the difference IN FULL on the date of treatment or within 30 days if the Insurance denies payment.

_____ _____ _____

Signature of Parent or Legal Guardian **Date** **Relationship to Patient**

KIDS TOWN PEDIATRIC DENTISTRY
PATIENT HEALTH HISTORY FORM

Patient Name:_____ DOB: _____/_____/_____ ☐ Male ☐Female

DOES THE PATIENT HAVE OR HAVE THEY EVER HAD ANY OF THE FOLLOWING: **PLEASE CHECK EACH BOX**

A.D.D.	☐YES ☐NO	Down Syndrome	☐YES ☐NO	**Respiratory	☐YES ☐NO
A.D.H.D	☐YES ☐NO	**Endocrine Disorder	☐YES ☐NO	Rheumatic Fever	☐YES ☐NO
AIDS/HIV Positive	☐YES ☐NO	Epilepsy or Seizures	☐YES ☐NO	Sinus Trouble	☐YES ☐NO
Anemia	☐YES ☐NO	Excessive Bleeding	☐YES ☐NO	Stroke	☐YES ☐NO
Asthma	☐YES ☐NO	**GI System Condition	☐YES ☐NO	Thyroid disorder	☐YES ☐NO
Autism	☐YES ☐NO	**Heart Condition	☐YES ☐NO	Tonsillitis	☐YES ☐NO
**Blood Disease	☐YES ☐NO	Heart Murmur	☐YES ☐NO	Tuberculosis	☐YES ☐NO
**Cancer	☐YES ☐NO	**Heart Surgery	☐YES ☐NO	**Tumors/Growths	☐YES ☐NO
Chemotherapy	☐YES ☐NO	Hearing Impaired	☐YES ☐NO	Vision Impaired	☐YES ☐NO
Cerebral Palsy	☐YES ☐NO	Hepatitis A, B or C	☐YES ☐NO	Venereal Disease	☐YES ☐NO
Cleft Lip	☐YES ☐NO	**Kidney Problems	☐YES ☐NO	**Other not listed	☐YES ☐NO
Cleft Palate	☐YES ☐NO	**Liver Disease	☐YES ☐NO		
**Congenital Birth Defect	☐YES ☐NO	**Mental Disorder	☐YES ☐NO		
**Congenital Heart Defect	☐YES ☐NO	**Physical Disability	☐YES ☐NO		
**Developmental Delays	☐YES ☐NO	Teen Pregnancy	☐YES ☐NO		
Diabetes	☐YES ☐NO	Radiation Treatment	☐YES ☐NO		

If yes for any above condition, please be specific in diagnosis and treatment:

DOES YOUR CHILD HAVE ALLERGIES TO ANY OF THE FOLLOWING:
☐ Local Anesthetic ☐Penicillin/Amoxicillin ☐Sulfa ☐Latex ☐Codeine ☐Other medications

PLEASE LIST ANY MEDICATIONS YOUR CHILD IS TAKING AND WHAT THEY ARE TAKING IT FOR: _____

_____

MEDICAL HISTORY:
Name of Primary Physician? _____ Date of last Medical exam?_____
Is your child currently under the care of a physician for any reason other than wellness checks? ☐YES ☐NO
If yes, what for? _____
Has your child ever had a traumatic medical/dental related injury? ☐YES ☐NO If yes, what?_____When?_____
Has your child ever been hospitalized? ☐YES ☐NO If yes, what for?_____ When?_____

Does your child have any of the following oral habits? ☐finger/thumb sucking ☐pacifier ☐nail biting/biting ☐lip sucking ☐grinding

The information I have given is correct to the best of my knowledge. I understand that it is my responsibility to inform this office of any changes to my child's medical status.

_____ _____
Signature of Parent or Guardian Date

HIPAA Information and Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been *our* practice for years. This form is a "friendly" version. A more complete text is posted in the office.

What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you the quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.gov

We adopted the following policies:

1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient's condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff. You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.

2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S. mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.

3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.

4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.

5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manager or the doctor.

6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.

7. We agree to provide patients with access to their records in accordance with state and federal laws.

8. We may change, add, delete, or modify any of these provisions to better serve the needs of both the practice and the patient.

9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.

I, _____ Date _____ do hereby consent and acknowledge my agreement to the terms set forth in the HIPAA INFORMATION FORM and any subsequent changes in office policy. I understand that this consent shall remain in force from this time forward.

CONSENT TO PROCEED

I authorize Dr. Brett Packham or Dr. Renn Veater and/or such associates or assistants as they may designate to perform those procedures as may be necessary or advisable to maintain the dental health for any minor child or other individual(s) for which I have responsibility, including arrangement and/or administration of any sedative including but not limited to nitrous oxide, topical anesthesia, oral anesthesia, analgesic, palliative, therapeutic and/or surgical treatment. I understand that the administration of local anesthetic may cause an adverse reaction or side effect(s) which may include but are not limited to: bruising, hematoma, cardiac stimulation and temporary or rarely permanent numbness and muscle soreness. I do voluntarily assume any and all possible risks including the risk of substantial and serious harm which may be associated with general preventive and operative treatment procedures in hopes of obtaining the potential desired results, which may or may not be achieved for my benefit or the benefit of my minor child or ward. I acknowledge that the nature of purpose of the foregoing procedures has been explained to me and I have been given the opportunity to ask questions.

I understand that if my child needs additional work done the doctors do their best to treatment plan at the initial exam, however there are certain items when they are unable to get full exam or proper x-rays taken, therefore I understand that treatment may change once my child is brought back to complete the treatment. I acknowledge that Kids Town Pediatric Dentistry will do their best to inform me of any changes before they are completed, however due to the nature of some appointments they may not have the opportunity to do so. I acknowledge that it is still my responsibility to pay IN FULL any additional or unplanned treatment done for my child.

I understand that Kids Town Pediatric Dentistry does NOT offer Amalgam(silver) Fillings therefore if my insurance company only pays for those specific fillings I understand it is my responsibility to cover the difference between the Fee's charged by Kids Town Pediatric Dentistry and what my insurance will allow. I also understand that if my insurance has restrictions and/or limitations on the allowed amount of X-rays and Fluoride treatments per year it is MY responsibility to let Kids Town know if I would like them done at each appointment. I am aware that if my child needs a crown(s) done, Kids Town Pediatric Dentistry will use Stainless Steel crowns to complete treatment as they are the most durable, long lasting and cost efficient method of treatment.

_____ _____

Signature of Parent or Legal Guardian Date

FINANCIAL AGREEMENT

If the patient does not have dental insurance, payment in full is expected on the day of service. If the patient does have dental insurance, the responsible party will pay the ESTIMATED portion and deductible on the day of service. The Insurance will be billed as a courtesy, however, please be aware if the insurance does not pay within 60 days' payment in full is expected from the responsible party.

Because it is YOUR insurance plan YOU are ultimately responsible for knowing and executing the requirement of your insurance plan. We strongly suggest you call your insurance to verify your plan benefits. NO insurance company will guarantee an exact payment. Please keep in mind that all insurances' relay a disclaimer that states that they are only giving general information when we call to verify your benefits. We will do everything we can to assist you in obtaining the maximum of your insurance benefits, however, the insurance is a contract between YOU and YOUR insurance carrier, therefore you are ultimately responsible for knowing the benefits, coverage, frequency limitations, exclusions, deductibles, maximum yearly benefits limits and/or any other restrictions your insurance plan may include. You are ultimately responsible for payment in FULL on your account.

I understand that insurance companies pay on usual and customary fee schedule and that the fees charged by the Doctor are the actual fees. If my Insurance is not contracted with Kids Town, I am responsible for the difference between the doctor's fee and the insurance fee. I understand the doctor will be using white filling material; some insurance companies will reduce the fee to a silver rate. It is my responsibility to pay the difference if any between the two fees. I understand that it is the Doctors recommendation that my child have a full exam, x-rays and a prophy/fluoride treatment done every 6 months. If my insurance does not cover it that often, it is my responsibility to let the staff know before my child goes back to their appointment. I understand that if my child has been referred by another dentist my insurance may not cover the cost of the exam or x-rays due to plan limitations, and it is my responsibility to pay.

When scheduling work with Oral or IV Sedation, I understand that my insurance WILL NOT generally cover this charge. Sedation fees will be due IN FULL along with all estimated dental co-payments on the date of service. I understand that for regular appointments there is a $25.00 fee for broken or appointments canceled without 24-hour notice and for IV/Surgical Center appointments there is a $100.00 fee for no-show appointments or appointments canceled without 48-hour notice.

There will be a $35.00 fee assessed to your account on all returned checks or non-sufficient funds for credit card transaction. I agree to pay interest of 1.5% per month or 18% APR on any account over 30 days past due as well as the cost of any re-billing fee, no-show fee and certified letter fee. I understand that Kids Town does NOT do payment plans unless it is a Pre-Treatment payment plan but understand if not paid prior to the treatment date the remaining balance will be due IN FULL or treatment will not be completed. Any accounts not paid in full within 90 days will be turned over to our Collection Agency with an additional 33.3% collection fee. The responsible party also agrees to pay all attorney fees and court costs associated with collection for services rendered. I understand that it is MY responsibility to provide a change in address including telephone number if any in a timely manner to avoid any delay in billing.

_____ _____

Signature of Parent or Legal Guardian Date

KIDS TOWN PEDIATRIC DENTISTRY

We are so grateful you chose to visit our office today. We would love to know how you learned about Kids Town. Please check all of the places you have seen us or heard about our office. Thank you!

- ☐ Drive By
- ☐ Internet Search
- ☐ Kids Town Website
- ☐ Insurance Website
- ☐ Facebook
- ☐ Instagram
- ☐ Employee Health Fair
  Name of Company_____
- ☐ Preschool or School Tour/Presentation
  Name of School_____
- ☐ Local High School program/banner
- ☐ Local Elementary School program/banner
  Name of School_____
- ☐ Family or Friend referral
  Name of family/friend_____
- ☐ Kids Town Employee Referral
  Name of Employee_____
- ☐ Doctor/Dentist/Orthodontist Referral
  Name of Doctor/Office_____
- ☐ Other _____