kidsdental
We Make Kids Smile!™

Patient Information

Patient Name: _____ Date: _____
First MI Last

Gender: _____ Nickname: _____ Child's Favorites (pet, toy, friend) _____

Birth Date: _____ Phone (to confirm appointments): _____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Previous DDS: _____ Date of Last Dental Visit: _____ Reason for this visit: _____

How often does your child brush their teeth? _____ How often do they floss their teeth? _____ Is your water fluoridated? _____

- How would you rate your child's smile? **Worst** 1 2 3 4 5 6 7 8 9 10 **Best**

- Does the child do any of the following? ☐ Thumb/Finger Sucking ☐ Tongue Thrusting/Sucking ☐ Grinding Teeth ☐ Heavy Snoring ☐ Mouth Breathing ☐ Lip Sucking/ Biting ☐ Breastfeeding ☐ Bottle @ Bedtime ☐ Pacifier

Does Child have or ever had any of the following diseases, medical conditions or procedures? Please check those that apply: **(By checking "NONE" you agree that you have read ALL conditions and that NO conditions currently apply to the child)**

☐ Allergies Environmental
☐ Allergic to Medication
☐ Allergies Food/Dye
☐ AIDS /HIV / ARC
☐ Anemia
☐ Autism
☐ Asthma or Lung problems
☐ Birth Defects _____
☐ Cancer/Tumors
☐ Cerebral Palsy
☐ Diabetes
☐ Difficulty w/Speech
☐ Epilepsy/Seizures
☐ Excessive Bleeding

☐ Cleft Lip/Palate
☐ Hearing Problems
☐ Hyperactivity /ADHD/ADD
☐ Hospitalization/Surgery
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis (A,B,C)
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Mouth Injuries

☐ Latex Allergy
☐ Leukemia
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatoid Arthritis
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis TB
☐ Artificial Bones/Joints
☐ Ulcers
☐ Prolonged Bleeding
☐ Codeine Allergy
☐ Penicillin Allergy

☐ OTHER
Please explain any checked responses
_____
_____
_____
_____
_____
_____
_____
_____
☐ **NONE**

List all current medications: _____
List any allergic reactions to medications: _____

- Is the child currently taking any of the following medications? ☐ Pain Medications (including Aspirin) ☐ ADD/ADHD Meds ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Muscle Relaxers ☐ Others: _____

- Does the child require pre-medication for dental visits? ☐ Yes ☐ No ☐ Don't Know

- Name of Physician: _____ Telephone Number: _____
Date of most recent medical examination: _____Child's Current Weight: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there is *ever* any change in health, I will inform KidsDental at the next appointment without fail.

_____ ***Date:*** _____

Signature of patient, parent or guardian

Family Information

Who is accompanying this child today? _____

Do you have LEGAL CUSTODY of this child? _____Does the child have brothers/sisters? _____ How many? _____

Names (circle if KidsDental Patient)_____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative

☐ Dental Office ☐ Yellow Pages ☐ Pediatrician ☐ Newspaper/Magazine ☐ School ☐ Work ☐ Other _____

Please list the name of person or office referring you to our practice so we may thank them: _____

Responsible Party Information

Name: _____ ☐ Male ☐ Female ☐ Married ☐ Single ☐ Divorced ☐ Other _____

Social Security #: _____ Birth Date: _____ DL #: _____

Mother's Phone (Home): _____ (Work): _____Ext: _____

Father's Phone (Home): _____ (Work): _____Ext: _____

Mother's Cell Phone: _____ Father's Cell Phone: _____

Responsible Party Address: _____

Street Apartment #

_____

City State Zip Code

Email Address (solely for the purpose of office/patient interaction): _____

Employment Information

Mother's Employer Name: _____ Occupation: _____

Father's Employer Name: _____ Occupation: _____

Insurance Information

Primary

Name of Insured_____ Social Security #: _____

Last First MI

Insured's Birth Date: _____ ID #: _____ Group #: _____ DL #: _____

Insured's Address: _____

Street City State Zip Code

Insured's Employer Name: _____

Address: _____

Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other _____

Insurance Plan Name and Address & Phone Number: _____

_____

_____

Consent for Services

Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the business manager in advance of the appointment. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

The undersigned is the person who has completed this form and is able to answer the above questions accurately. In addition, the undersigned has legal authority to obtain dental care for the above named child. I hereby authorize Drs. Holt, Sapozhnikov, Li, and/or other dentists and/or other health care providers as deemed necessary, to provide all necessary dental treatment as diagnosed. Patients who have insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services should the insurance company fail to remit payment for the claims in a timely manner. This office will prepare the patients insurance claims or assist in making collections from insurance companies as a courtesy for the patient as long as the account stays in "good standings" with KidsDental. This courtesy may be rescinded if the account of the guarantor enters into default at any point.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of sixty days from the date of the patient examination.

I grant my permission to you or your assignee to telephone me at home or at my work to discuss matters related to this form.

We invite you to discuss with us any questions regarding our services. The best dental health services are based on a friendly, Mutual understanding between provider and patient.

I have read the above conditions of treatment and payment and agree to their content.

_____ **Date:** _____ **Relationship to Patient:** _____

Signature of guarantor (financially responsible party)

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kidsdental®

Financial Guidelines

Thank you for choosing us as your child's Dentist. Our main concern is that your child receives the proper and optimal treatments needed to restore his or her dental health. We are committed to providing each patient with quality dental care. If you have any questions or concerns regarding our payment policies, please do not hesitate to ask our Office Manager.

We ask that all patients provide current health history and insurance information on our new patient registration form. Please read and sign our Financial Policy prior to seeing the doctor. We **must** be informed of medical history changes upon arrival at each visit.

Payment is due at the time of service. We accept cash, checks and, for your convenience, MasterCard, Visa, and Discover.

New patients will be required to pay for their first visit *unless* we have verified your dental benefits prior to the first visit. In certain instances we may accept assignment of insurance benefits; however, you must understand that:

- Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, non-covered/covered charges, co-insurance, coordination of benefits, or "reasonable an customary" charges other than to provide factual information as necessary. Please understand that our fees are based upon the specific procedure, the time involved, the materials used, and the expertise and knowledge used to place those materials- therefore what insurance deems *usual and customary* specific only to your insurance plan premiums, has no relevance in the determination of fee schedules.
- **We do not file secondary insurance**. We will provide you with a detailed statement so you may process your secondary insurance.
- **All charges are your responsibility whether your insurance company pays or not**. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
- Fees for these services, along with unpaid deductibles and co- payments are due at time of treatment.
- If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help speed things up.
- If the insurance company does not pay your balance in full within 90 days, we require you to pay the balance due and resolve any further issues with your contracted insurance carrier.
- **All accounts with a balance of 60 days or more will be subject to a monthly interest charge of 1.5% and may be forwarded to our collections attorney.**
- **Returned checks will be subject to a $33 service charge.**

Please note that, unless canceled at least 48 hours in advance, **you may be charged for missed appointments** at the rate of a normal office visit. Please call if you need to reschedule.

We do understand that temporary financial problems may affect timely payment of your balance. We encourage you to communicate any such problems so that we can assist you in the management of your account.

Again, thank you for choosing KidsDental. We appreciate your trust and the opportunity to serve you. Our goal is make dentistry fun for children so that they may establish the lifelong dental habits that are so important in maintaining good dental health.

Patients Name: _____ Parents Signature: _____Date: _____

Insurance Courtesy Notification

KidsDental will gladly file your dental insurance as a courtesy. However, please realize that the entire account balance is the obligation of the responsible party.

Please note that all claims are filed electronically to ensure receipt by the insurance company in a timely manner. After 30 days of non-payment a second claim will be submitted. In addition, your insurance company will be contacted to inquire on the status of the claim.

By signing below, you acknowledge that if your insurance company fails to remit payment after 60 days from date of service, the entire account balance is due in full by the responsible party.

Responsible Party _____ Date _____

PLEASE READ: I understand that the standard of care for a routine six month dental check-up as prescribed by the American Dental Association and the American Academy of Pediatric Dentistry includes, but is not limited to:

- Comprehensive / Periodic oral evaluation (D0150; D0120)
- A professional dental prophylaxis (D1110; D1120 – cleaning)
- A professional topical fluoride application (D1203; D1204)
- Diagnostic X-rays (D0220; D0230; D0240; D0272; D0274)

Individual insurance plan variables and guidelines may affect coverage and limit benefits for the above procedures. It is the responsibility of each policy holder to be familiar with their particular policy coverage prior to scheduling any visit. X rays are typically taken once per year unless otherwise ordered by the Dentist.

*** WE ARE CONSIDERED IN-NETWORK FOR MANY PLANS, BUT NOT ALL. IT IS THE RESPONSIBILITY OF THE POLICY HOLDER TO CONFIRM THE STATUS OF THE DOCTOR. IT IS ALSO THE RESPONSIBILITY OF THE POLICY HOLDER TO BE FAMILIAR WITH THE PARAMETERS OF THE INSURANCE PLAN. ***

Child's Name: _____

Responsible Party: _____ Date: _____

Play Structure Rules

1. **ALL CHILDREN must be supervised by parent or other adult guardian while playing on or near equipment at all times.**
2. **Children under the age of 3 must be accompanied by an adult while playing in the equipment.**
3. **No shoes allowed while playing on equipment.**
4. **No climbing on outside of equipment.**
5. **Nothing is allowed to be taken into the play equipment.**
6. **No running or jumping near equipment.**
7. **No entering play equipment from the slide area.**
8. **Absolutely no sedated children allowed in play equipment.**
9. **No children allowed in play equipment after dental treatment.**

Accompanied Minor Policy

****PLEASE NOTE THAT OUR OFFICE POLICY REQUIRES A**

PARENT/LEGAL GUARDIAN TO REMAIN IN THE OFFICE FOR THE

DURATION OF THE APPOINTMENT**

I agree to the above rules and policy, I also understand that I take full responsibility for my child's supervision and safety while he/she is playing on or near the play structure equipment.

_____ _____

Patient's name Date Parent or Guardian Date

Pediatric and Adolescent Dentistry

BEHAVIOR MANAGEMENT TECHNIQUES

The following information is provided so as to allow you to make informed personal decisions concerning your child's dental treatment after considering the risks, benefits and alternatives. Please read this form carefully and ask about anything you do not understand.

It is my intent that all professional care delivered in this office shall be of the best possible quality I can provide for your child. It is very important that you appreciate that all treatment decisions in this office are based on the philosophy that we treat our patients the same way we would want our own children treated. Providing a high quality of care can sometimes be made very difficult, or even impossible, because of the lack of cooperation of some child patients. Behaviors that can interfere with the proper provision of quality dental care include: hyperactivity, resistive movement, refusal to open the mouth or keep it open long enough to perform the necessary dental treatment, and even aggressive or physical resistance to treatment such as kicking, screaming and grabbing the dentist's hands or sharp instruments.

My goal is to help children master the dental experience. Some children may cry as part of this learning process. Childhood emotions are intense and crying is a natural release of anxiety and/or an avoidance scheme. All efforts will be made to obtain the cooperation of our patients by use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding.

There are several recognized management techniques that are used by pediatric dentists to gain cooperation of children, to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. We combine the following recognized techniques individually for each child:

- **Tell-Show-Do:** The child is told what is to be done using simple words and then shown what is to be done using a model or finger. Then the procedure is done exactly as told. Praise is given to reinforce positive behavior. Children have less anxiety when they know what to expect.
- **Positive Reinforcement:** This technique rewards the child who displays any desirable behavior. Rewards include praise, compliments, a pat on the back, a gentle hug, a prize, etc…
- **Voice Control:** The attention of a child exhibiting disruptive behavior is gained by changing the volume tone of the dentist's voice. Content of the conversation is less important than the abrupt or sudden nature of the voice change.
- **Mouth Prop:** A device placed in the child's mouth to prevent accidental closing and/or injury. This also allows the jaw muscles to relax for ease of swallowing.
- **Physical Restraint by Dentist/Assistants:** The restraining of the child from undesirable movement by holding down the child's hands or upper body, stabilizing the child's head and/or controlling leg movements with the intention of preventing possible injury.
- **Nitrous Oxide/Oxygen Analgesia:** Nitrous oxide and oxygen analgesia is also known as "laughing gas" or "happy air." It smells good and its effects are completely removed five minutes after withdrawal. Many children find it helpful in managing dental anxiety. It provides a sensation of well being.
- **Conscious Sedation:** Sometimes a sedative drug is used to relax a child who does not respond to other behavior management techniques. Often this is an extremely young child who has extensive decay and who is unable to cooperate in the usual manner. This drug is administered orally and may be used in conjunction with nitrous oxide and oxygen analgesia. Sedations are not performed without parents being further informed and obtaining their specific consent for this procedure.
- **Hospital Dentistry or IV Disassociative Sedation:** For some children with medical complications, extensive decay at a very young age or in instances when conscious sedation is ineffective, dental treatment can be accomplished in a hospital operating room under general anesthesia or by IV disassociative sedation in the dental office. Additional information is provided to parents regarding this form of treatment.

I hereby authorize and direct Drs. Holt, Li, Sapozhnikov, and/or other dentists and/or other health care providers as deemed necessary, to utilize the behavior management techniques listed above on this form to assist in the provision of the necessary dental treatment with the exception of: (if none, state so)

_____.

I hearby acknowledge that I have read and understood this consent and that all questions about the behavior management techniques described have been answered in a satisfactory manner.

Child's name: _____

Parent/Legal Guardian's Signature: _____ Date: _____

Consent for Use of Disclosure of Health Information
& Acknowledgement of Receipt of Notice of Privacy Practices

Section A: Patient Giving Consent

Patient's Name: _____

Address: _____

Telephone: _____ **Social Security Number:** _____

Section B: To the Patient---Please read the following statements carefully

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this CONSENT. Our NOTICE provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our NOTICE accompanies this CONSENT. We encourage you to read it carefully and completely before signing this CONSENT.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:
Yanez Soto, 4112 N. Josey Lane, Suite 128, Carrollton, Texas, 972-394-2140.

Right to Revoke: You will have the right to revoke this CONSENT at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this CONSENT will *not* affect any action we took in reliance on this CONSENT before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke this CONSENT.

SIGNATUREYou May Refuse to Sign This---You are entitled to a copy of this consent after you sign it****

I, _____, have had full opportunity to read and consider the contents of this CONSENT form and your Notice of Privacy Practices. I understand that, by signing this CONSENT form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations. I have reviewed a copy of this office's Notice of Privacy Practices.

Signature: _____Date: _____

If this CONSENT is signed by a personal representative on behalf of the patient, complete the following:

Patient Representative (Print): _____

Relationship to Patient: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect 04/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example: **Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of
(including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health and safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $0 for each page, $___ per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Ms. Yanez Soto
Telephone: 972-378-5437
Fax: 972-378-0048
E-mail: yanez@kidsdentalonline.com
Address: 3001 N. Dallas Pkwy
Plano, TX 75093