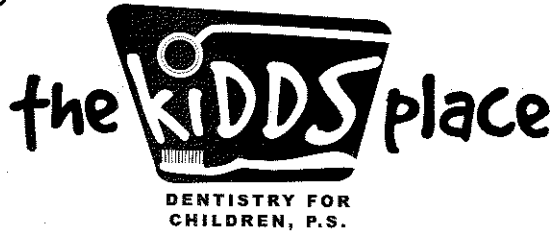


Welcome to...



We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventative care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

TELL US ABOUT YOUR CHILD

Today's Date
Child's Name
Nickname: Sex:
Child's birthdate: Age:
School: Grade:
Child's Home Address:

CITY STATE ZIP CODE

Home Phone

Name/Age of Siblings:

Previous Dentist:

Last Visit Date:

Who may we thank for referring you?

IN CASE OF EMERGENCY CONTACT: Name:

WK# HM#

Relationship:

MOTHER'S INFORMATION (Stepmother Guardian)

Name:
Address:
WK# HM#
Employer:
Occupation:
SS# DL#

FATHER'S INFORMATION (Stepfather Guardian)

Name:
Address:
WK# HM#
Employer:
Occupation:
SS# DL#

PERSON RESPONSIBLE FOR ACCOUNT:

Name: Relation:

Billing Address (if different from patient):

CITY STATE ZIP CODE

PRIMARY DENTAL INSURANCE

Insurance Co. Name:
Insurance Co. Address:
Insurance Co. Phone #:
Group # (Plan, Local or Policy 3):
Insured's Name:
Relationship to Patient:
Insured's Birthdate: SS#
Insured's Employer:

SECONDARY DENTAL INSURANCE

Insurance Co. Name:
Insurance Co. Address:
Insurance Co. Phone #:
Group # (Plan, Local or Policy 3):
Insured's Name:
Relationship to Patient:
Insured's Birthdate: SS#
Insured's Employer:

I hereby authorize payment to The KiDDDS Place of insurance benefits otherwise payable to me. I authorize Dr. Evans and Dr. Luchini to administer such medications and perform such diagnostic and therapeutic procedures as may be necessary for proper dental care. The information on the page is true and correct to the best of my knowledge.

Signature

Date

Circle One: Parent Guardian

Patient Health Information

Patient's Name _____

Date _____

YES NO

Is your child currently under the care of a physician?

If yes, Why? _____

Child's Physician: _____

Phone #: _____

Last Visit: _____

Has your child ever had general anesthesia or sedation?

If yes, when: _____

Were there any complications: _____

Please describe the child's health:

Good

Fair

Poor

Is your child allergic to anything?

IF YES, WHAT: _____

Please list all drugs the child is currently taking: _____

Does your child require antibiotics prior to invasive dental procedures? YES NO

YES

NO

If yes, please explain: _____

Has the child been diagnosed or treated for any of the following conditions:

Yes No

- Anemia
- Arthritis
- Asthma
- Autism
- Bronchitis
- Cancer
- Cerebral Palsy
- Cleft Lip / Palate
- Convulsions / Seizures
- Developmentally Delayed
- Diabetes
- Epilepsy
- Eye Problems
- Excessive Bleeding
- Fainting
- Gastrointestinal (stomach)

Yes No

- Hearing Loss
- Heart Disease
- Heart Murmur
- Hemophilia
- Hepatitis - Type _____
- Immunodeficiency
- Leukemia
- Measles / Mumps
- Mouth Breathing
- Nutritional Deficiency
- Orthopedic Problems
- Pneumonia
- Polio
- Psychiatric Disorder
- Rheumatic / Scarlet Fever
- Scoliosis

Yes No

- Sickle Cell Anemia
- Sinus Problems
- Snoring at Night
- Sore Throat - Frequent
- Spina Bifida
- Syndrome
- IF YES, WHAT: _____
- Tetanus
- Tonsils / Adenoids
- Tuberculosis
- Whooping Cough
- Other _____

Is there anything else you think we should know about your child? _____

Has your child been seen by a dentist before? Y N Date last seen _____ Name of Dentist _____

Has your child ever had a serious/difficult problem associated with dental work? Y N

Please explain: _____

At what age did your child stop bottle/breast feeding? _____

Is the child's water fluoridated? Y N Unknown

Is the child taking any fluoride supplements? Y N

Does the child suck his/her thumb or fingers or pacifier? Y N

Would you like to speak to the Doctor privately about any problem? Y N

I CERTIFY THAT I HAVE READ AND UNDERSTAND THE ABOVE QUESTIONS. I CERTIFY THAT THE ABOVE INFORMATION IS COMPLETE AND ACCURATE.

Signature of person completing this form: _____

Date: _____

Relationship to patient: _____

Dentist's Signature: _____

Date: _____

Welcome to...



We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventative care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Office Policy Regarding Scheduled Appointments

Our office has certain guidelines that we feel are essential to the successful and continued treatment of your child. We look forward to providing years of dental care for your child and encourage your cooperation and support.

- ✓ In order to help us continue to schedule efficiently, at least 24 hour notice is required to cancel an appointment. Another patient who needs our care could be scheduled if we have sufficient time to notify them. We realize that unexpected things can happen, but we ask for your assistance in this regard. You may be asked to seek care elsewhere after two missed appointments.
- ✓ Please be on time for each appointment. We always try to see each child as close to the appointed time as possible. However, due to emergencies, there may be times that you will need to wait a short while. We ask for your patience during these times. If you have waited more than 15 minutes, please mention it to our receptionists.
- ✓ We find that most children do extremely well on their own. As the parent you are welcome to accompany your child into the treatment area. You are a vital member of our team. You know your child and what will work best for them. Depending on the situation, we may ask that you allow your child to accompany our staff through the dental experience. We are all highly experienced in helping children overcome anxiety. Separation anxiety is not uncommon in children, so please try not to be concerned if your child exhibits some negative behavior. This is normal and will soon diminish. Studies and experience have shown that most children over the age of 3 react more positively when permitted to experience the dental visit on their own and in an environment designed for children. Expect your child to do well and enjoy their visit to our office and chances are they will do just that!
- ✓ Nitrous Oxide ("Laughing Gas") is a mild relaxant commonly used to relieve anxiety during a restorative appointment. It is only recommended when the doctor believes that it is in your child's best interest. It is important to all of us that your child's dental visit be as pleasant as possible.
- ✓ If you have any questions or concerns, please do not hesitate to ask us. We make a concerted effort to make your visit as enjoyable as possible. Our goal is to provide a great appointment experience with outstanding service. Our doctors and staff maintain the highest standards in pediatric dental care.

I have read and understand the office policies and agree to follow the guidelines discussed above.

Name _____ Date _____



Financial Policy

Pediatric dentistry is an important part of a child's overall health. Payment in full is due at the time of service unless other arrangements have been made. All payment arrangements must be made in advance with our financial coordinator. For your convenience, we offer several payment methods. We accept cash, checks and credit cards. Please provide us with your insurance information before your first appointment.

Methods of Payment

- ❖ Cash Accounts: We offer a 5% discount for payment in full on the day of service. Any payment arrangements need to be made with our financial coordinator. All non-sufficient funds checks are subject to a return check fee.
- ❖ Credit Card: MasterCard or Visa
- ❖ DSHS Medicaid
- ❖ Insurance Accounts: Your dental policy is a contract between you and the insurance company. We are not a party to that contract. Not all services are covered in all contracts. Some insurance companies arbitrarily select certain services that they will not cover. You need to understand the scope and limitations of your insurance policy. We file your claims for you as a courtesy.

At the time you receive our services, you must pay all estimated fees and deductibles not covered by your insurance plan.

You will need to provide us with accurate insurance and employment information. Inaccurate information delays claims and can result in additional costs and inconvenience for you. If your claim has not been paid within 60 days of the date of service, the entire balance is due from you. You then can be reimbursed directly from the insurance company.

Should it be necessary to take action to collect any amount owing under this agreement, you will be responsible for all costs incurred to collect including but not limited to, collection agency fees, attorney fees and court costs, and late fees on your unpaid balance. In addition, you will be asked to seek dental care elsewhere for your child.

I understand that where appropriate, Credit Bureau Reports may be obtained. I have read, understand and agree to the provisions of this Financial Policy.

Signature: _____ Relationship to Patient: _____

Your Name (please print): _____ Date: _____

Patient Name: _____

Patient D.O.B.: _____