## Patient Information

Patient Name:______________________________________________ Date:____________

Last First MI

Patient Date of Birth:_________________________ ☐Male ☐Female Age of Child_______

Address:______________________________________________________________

Street Apartment #

______________________________________________________________

City State Zip Code

Guardian Name:________________________________________________________

Last First MI

Phone (Home):__________________(Work):__________________(Cell):________________

Email Address: ____________________________________________________________

## Health Information

**Has patient ever had any of the following? Please check those that apply:**

| | | | |
|---|---|---|---|
| ☐AIDS/HIV | ☐Head injuries | ☐Nervous Disorders | ☐Stomach Problems |
| ☐ADD/ADHD | ☐Heart Disease | ☐Pacemaker | ☐Stroke |
| ☐Allergies (seasonal) | ☐Heart Murmur | ☐Radiation Treatment | ☐Tuberculosis |
| ☐Anemia | ☐Hemophilia | ☐Respiratory Problems | ☐Venereal Disease |
| ☐Asthma | ☐Hepatitis | ☐Rheumatic Fever | ☐Codeine Allergy |
| ☐Autism | ☐Jaundice | ☐Seizure ________ | ☐Food Allergy |
| ☐Blood Disease | ☐Kidney Disease | ☐Sickle Cell Disease | ☐Latex Allergy |
| ☐Cancer | ☐Liver Disease | ☐Sickle Cell Trait | ☐Penicillin Allergy |
| ☐Cerebral Palsy | ☐Mental Disorders | ☐Sinus Problems | ☐Other |
| ☐Diabetes | ☐Mental Retardation | ☐Skin Disorder(s) | ☐____________ |

**Has the above mentioned patient ever had any complications following dental treatment? ☐Yes ☐No**

**If yes, please explain ______________________________________________________**

**Has the above mentioned patient been admitted to a hospital or needed emergency care in the past two years?**

**☐Yes ☐No If yes, please explain ______________________________________________**

**Is the above mentioned patient now under the care of a physician? ☐Yes ☐No**

**If yes, please explain ______________________________________________________**

**Name of Physician __________________________________________________________**

**Is the patient currently taking any medications? ☐Yes ☐No**

**If yes, please explain ______________________________________________________**

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

**_____________________________________________ ________________________**

**Signature of parent or guardian Date**

**Whom may we thank for referring you to our practice? ☐Patient, friend, relative ☐Dental office ☐Yellow Pages ☐Internet ☐School ☐Work ☐Newspaper ☐TV Name of person or office referring you ___________________________**

## Medical Information

☐Yes ☐No Are your child's immunizations up to date?

☐Yes ☐No Is your child taking any medications at this time? If yes, please explain:
____________________________________________________________

☐Yes ☐No Has your child ever had a problem with his or her speech, sight, hearing, or learning disabilities?
If yes, please explain: ____________________________________________

☐Yes ☐No Has your child ever received an injury or had a fall to the head, jaws, mouth, or teeth?
If yes, please explain: ____________________________________________

## Dental History

☐Yes ☐No Is this your child's first visit to a dentist? If not, date of last visit: ___________________
Dentist name: ____________________________________________________________
When was your child's last dental x-rays taken? ______________________________

☐Yes ☐No Has your child had a toothache recently?

☐Yes ☐No Does your child brush his/her teeth?
☐Yes ☐No Do you assist with brushing?
☐Yes ☐No Is your child presently using a nursing bottle? Age discontinued ____________

☐Yes ☐No Does your child have a history of thumb sucking? ___Finger sucking?___Pacifier use?
____ Nail biting? ____

☐Yes ☐No Does your child snore at night? ___Mouth breathe? ____ Grit or grind their teeth?____
Other habits? ___________________________________

☐Yes ☐No Do you live in a fluoridated water area? Don't know ____________

☐Yes ☐No Does your child play organized sports? Type? ______________________________

☐Yes ☐No Has your child had a frightening or painful dental experience?

What have you told your child about today's dental appointment?
____________________________________________________________

☐Yes ☐No Has your child had any problems with previous dental treatment?
If yes, please explain: ________________________________________________

☐Yes ☐No Does your child have a dental condition about which you are especially concerned?
If yes, please explain: ________________________________________________

☐Yes ☐No Has your daughter began menstruation?

## Responsible Party Information

***Must be present with proper ID to be considered as the Responsible Party***

Name: ______________________________

☐Male ☐ Female ☐Married ☐Single ☐Other______________________

Relationship to patient: ______________________________

Social Security #: ____________ Birth Date: ____________

Phone (Home): ____________ (Work): ____________(Cell): ____________

Address: ______________________________Apt. # ____________

______________________________

City State Zip Code

## Responsible Party's Employment Information

Employer Name: ____________ Occupation: ____________

Address: ______________________________

Street City/State Zip Code Phone#

Commanding Officer: ____________ Phone (Work): ____________

## Insurance Information

Primary

Name of Insured: ______________________________

Last First MI

Birth Date: ____________ ID# ____________ Group# ____________

Name of Insurance Plan: ______________________________

Secondary

Name of Insured: ______________________________

Last First MI

Birth Date: ____________ ID# ____________ Group# ____________

Name of Insurance Plan: ______________________________

## Consent for Services

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from the patients for the costs incurred in their care and financial responsibility from each patient must be determined prior to treatment.
All emergency dental services or any dental services performed without previous financial arrangements must be paid in full before services are performed.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he/she is responsible for payment. This office will help prepare insurance forms and assist in collecting from insurance companies and will credit such collections to the patient's account. However, this dental office cannot render services on the assumption that the charges will be paid by the insurance company. A service charge of 1.5% per month will be charged on the unpaid balance of all accounts exceeding 60 days.

In consideration for the services rendered to me, or at my request, I agree to pay the reasonable value of said services at the time treatment. I further agree that the reasonable value of said services shall be as billed unless objected to, within the time for payment thereof. I also agree that a waiver of any breach shall not constitute a waiver of any further term or condition. I agree to pay all costs and reasonable attorney fees if suit be instituted hereunder.

_________________________________________ Signature of Responsible Party Date___________________________

## Office Financial Policy

- I understand that I am responsible for all fees related to my dental care and treatment.
- I understand that full payment for all dental treatment is to be paid at the time the treatment is rendered.
- I understand that any and all account balances over 30days may incur a monthly interest charge and the maximum rate.
- I understand that if a check, or other instrument, or any electronic authorization or debit sent or provided to Simply Children's Dentistry, Inc. for payment is not honored upon first presentment, regardless of the reason, even if the check, instrument or electronic authorization is later honored, I will be charged the maximum allowable service charge of $30.
- I understand that if my account is not timely paid, my account may be turned over to a collection agency. In addition to paying my balance, I agree to pay all reasonable attorney's fees, collection and/or court costs.

## Broken And/Or Missed Appointments

Simply Children's Dentistry, Inc. reserves the right to charge a $35 fee for any appointment not kept by the patient. After two (2) broken or missed appointments, the dentist retains the right to discontinue elective treatment.

## Patients With Dental Insurance

- I understand that my insurance policy is a contract between my insurance company and myself. Simply Children's Dentistry, Inc. and its employees are not parties to my contract with my insurance.
- I understand that I am ultimately responsible for any and all balances, even if my insurance company agrees to pay a balance and later does not pay.
- I understand that I may be given the option of only paying my estimated portion (portion not covered by insurance) at the time of services. As a courtesy, the office will send my claim to my insurance company. If my insurance company fails to pay the balance, the balance is my responsibility and payment is due in full.
- I understand that if my first visit is an emergency visit, I will be responsible for payment of services in full at the time of the visit. As a courtesy, Simply Children's Dentistry, Inc. will provide to me the necessary documents to file to my insurance company for reimbursement.

## For Patients With Insurance, Please Initial The Billing Option Of Your Choice

____ I will pay my total balance at the time of service and will seek reimbursement directly from my insurance company.

____ I will pay only my estimated portion at time of service and have my insurance pay the office. If my insurance company fails to pay the balance, it remains my responsibility and I must pay all amounts due. If this is my first visit and it is an emergency visit, I understand that payment for all services is due at time

I have read, understood and agree to the terms of the above stated policies.

_______________________________________ _______________________________

Signature of Parent/Guardian Date

**Simply Children's Dentistry, Inc.**

**Notice and Consent Form**

**Patient's Name: ______________________________________________________**

**Parent/Guardian:_____________________________________________________**

Simply Children's Dentistry, Inc. wants you and your child's visit to be both educational and enjoyable. Therefore, we request that you read this **Notice and Consent Form** carefully. This form is meant to provide information on some of the routine procedures we perform. If you do not have any questions or concerns we ask that you complete the form and sign the bottom of the page giving us your consent to perform the listed procedures if deemed necessary.

Please place an initial next to each paragraph indicating that you understand and consent to the procedure.

**____** **Consent to receive dental treatment.** I consent and authorized Dr. Kamiti Harden and her employees to examine, clean and provide dental treatment for my child. I further consent and authorize the taking dental x-rays as may be considered necessary by Dr. Kamiti Harden to diagnose and/or treat my child. I will allow photographs to be taken of my child and/or child's teeth for diagnostic and educational purposes.

**____** **Consent to receive Nitrous Oxide/Oxygen Sedation.** I consent and authorize Dr. Kamiti Harden to use **Nitrous Oxide** (laughing gas) during treatment of my child. Nitrous Oxide/Oxygen sedation is generally safe and effective technique to reduce or eliminate anxiety and enhance effective communication. Its onset and recovery is rapid. Additionally, Nitrous Oxide aids in reducing pain and the gag reflex. Dr. Flowers uses nitrous oxide for all patients who she has to give an injection to. There is a fee associated with this procedure.

**____** **Consent to immobilization.** I understand and agree that it may be necessary for Dr. Kamiti Harden to use a papoose board (hug blanket) during the dental procedure to prevent injury and enable her to safely provide the necessary treatment for my child. There is a fee associated with this procedure. This procedure is not covered by most insurance companies.

**______________________________________________** **Date ___________________________________**
**Parent/Guardian Signature**

## Acknowledgement of Receipt of Notice of Privacy Practices

*You May Refuse to Sign this Acknowledgement*

I acknowledge that I have read and understand **Simply Children's Dentistry, Inc.** *Notice of Privacy Practices.*

______________________________

**Print Name**

______________________________

**Signature**

______________________________

**Date**

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**For Office Use Only**

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

☐ **Individual refused to sign.**

☐**Communication barriers prohibited obtaining the acknowledgement.**

☐**An emergency situation prevented us from obtaining acknowledgement.**

☐**Other (please specify).**

______________________________

______________________________

______________________________

## Policy on Parental Presence

At **Simply Children's Dentistry** our goal is to make you and your child's visit as enjoyable, fun and comfortable as possible. It is very normal for children to be scared and apprehensive, and we are trained to handle this. We ask that when children are receiving treatment, that the parents remain in the waiting area, unless the parent fully understands the **Silent Parent Policy.** We have noticed that some children are more cooperative when no parent is present, while few are cooperative when the parent is present.

**Some of the reasons for this policy are:**

- Parents often repeat and/or inject orders, becoming a barrier to development of the rapport between the doctor and the child.
- The child often becomes confused and divides his/her attention between the parent and the doctor.
- The doctor divides attention between the parent and the child and it is during this time when the doctor wants to focus totally on the needs of the child.

The doctor is fully aware that the parent can be a major asset in supporting and communication with a disabled child, or a young infant. While there are **exceptions** to every policy, those exceptions are left to the doctor's discretion. Please remember that our number one goal is the safety and comfort level of your child. When and if the doctor feels that the parent can help calm the child during a procedure, the doctor will ask that the parent comes back. If it is your first visit, which is **ALWAYS** an examination, the parent is allowed to come back with the child. If two parents are present, we ask that only one come back with the child, and preferably the one that the child will be more cooperative with.

| **Parent/Guardian Signature** | **Date** | **Doctor's Signature** |
|---|---|---|