KIDS TOWN PEDIATRIC DENTISTRY

PATIENT INFORMATION **Today's Date** _____

Welcome to our dental office, where we provide individualized care for infants, toddlers, children and special needs patients. Our focus is on prevention and early management of dental disease. We are honored that you have entrusted your child's care to us. We take great pride in providing a comfortable experience for children and their families.

How did you hear about us? ☐Internet/Google ☐Facebook ☐Drive by ☐HTV or Value Pages

☐Insurance ☐Patient/Parent:_____ ☐Other:_____

☐Doctor Referred:_____

CHILD INFO

Name: _____ (First) (Last) Goes by: _____

Birth date: _____ ☐Male ☐Female

Home address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____

PARENT/GUARDIAN INFO ☐**Mom** ☐**Dad** ☐**Guardian** / ☐**Married** ☐**Divorced** ☐**Single**

Name: _____ Goes by: _____

D.O.B. _____ Social Security #: _____

Address: (if different than child's) _____

City: _____ State: _____ Zip: _____

Best contact phone #: _____ ☐Home ☐Cell ☐Work

Email: _____ Driver's License #_____

PARENT/GUARDIAN INFO ☐**Mom** ☐**Dad** ☐**Guardian** / ☐**Married** ☐**Divorced** ☐**Single**

Name: _____ Goes by: _____

D.O.B. _____ Social Security #: _____

Address: (if different than child's) _____

City: _____ State: _____ Zip: _____

Best contact phone #: _____ ☐Home ☐Cell ☐Work

Email: _____ Driver's License #_____

Is there anyone you would like to designate to bring your child in for dental appointments other than mom/dad? If yes, please list: _____Relationship: _____

EMERGENCY CONTACT: Please list a name and phone number of someone we can contact other than mom/dad: _____ Phone: _____

*If you have BCBS or GEHA Medical Insurance you may have limited dental coverage that we would be required to bill as primary so please list if this applies to your child.

DENTAL INSURANCE PRIMARY

Insurance Company name: _____

Insurance contact phone number: _____

Policy/Subscriber Name: _____

Policy/Subscriber Birth date: _____ Social Security #_____

Policy/Subscriber Number: _____ Group #_____

Group Name: _____ Employer: _____

Relationship to patient: ☐Mom ☐Dad ☐Step-parent ☐Grandparent / Guardian

DENTAL INSURANCE SECONDARY

Insurance company name: _____

Insurance Contact phone number: _____

Policy/Subscriber Name: _____

Policy/Subscriber birth date: _____ Social Security #_____

Policy/Subscriber Number: _____ Group #_____

Group Name: _____Employer: _____

Relationship to patient: ☐Mom ☐Dad ☐Step-parent ☐Grandparent / Guardian

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.

_____ **Initial that you read and understand your Insurance responsibility**

KIDS TOWN PEDIATRIC DENTISTRY

Patient Health History

PATIENT NAME: _____DOB: _____

DENTAL HISTORY:

Why is your child here today? ☐First Dental Visit ☐Checkup ☐Other_____

Has your child been to the Dentist before? ☐Yes ☐No If yes, date? _____

How was your child's experience (check one) ☐Excellent ☐Good ☐Fair ☐Poor?

Has your child had dental x-rays taken before? ☐Yes ☐No

Is your child currently taking fluoride? ☐Yes ☐No If yes, how often? _____ x daily

Does the patient have any of the following oral habits?
☐finger or thumb sucking ☐pacifier ☐nail biting ☐lip sucking ☐biting ☐grinding

Is the patient breast feeding or still on a bottle? ☐Yes ☐No Using sippy cup? ☐Yes ☐No

AT HOME DENTAL CARE:
How often does your child brush their teeth? _____ x daily. Who brushes? ☐Child ☐Parent
How often does your child floss their teeth? _____ x daily. Who flosses? ☐Child ☐Parent

MEDICAL HISTORY:

Name of Primary Physician? _____
Date of last Medical exam? _____Are your child's shots current? ☐Yes ☐No
Is your child currently under the care of a physician for any reason? ☐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? _____

Health History

Patient Name: _____ DOB: _____

Does the patient have or have they ever had any of the following?

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

**** IF YES FOR ABOVE CONDITIONS**, 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_____

Please list any medications your child is on and what they are taking it for:

_____

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 in my child's medical status.

_____ _____

Signature of parent or guardian Date

KIDS TOWN PEDIATRIC DENTISTRY

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 my 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

PAYMENT POLICY

ALL CO-PAYS AND DEDUCTIBLES ARE DUE ON THE DATE OF SERVICE

To accommodate this we have several different payment options for you.

Payment Options: (You can choose from)

- Cash, Check, Visa, MasterCard, American Express or Discover

- NO INTEREST PAYMENT PLANS FROM **CARE CREDIT**
    - Allows you to pay over time with NO Interest
    - Convenient, low monthly payment plans
    - No annual fees or pre-payment penalties

For patients with dental insurance we will bill your insurance for you however, quotes given are **ESTIMATES ONLY** no Insurance company will guarantee payment. Ultimately it is your responsibility to know your insurance coverage, deductibles and maximum benefit limits. Any co-pays or deductibles will be due on the date of service.

Payment plans are available **ONLY if pre-paid prior to the completion of treatment. **WE DO NOT ALLOW PAYMENT PLANS AFTER TREATMENT IS COMPLETED.**
There will be a $25.00 fee for all returned checks.

KIDS TOWN PEDIATRIC DENTISTRY

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

KIDS TOWN PEDIATRIC DENTISTRY

NOTICE OF PRIVACY PRACTICES FOR

KIDS TOWN PEDIATRIC DENTISTRY, PLLC &

KIDS TOWN PEDIATRIC DENTISTRY OF SYRACUSE, PLLC

LOCATED AT EITHER:

3540 West 6000 South, Suite #200, Roy, UT 84067

2940 North Church Street, Suite #301, Layton, UT 84040

780 South 2000 West, Building F-2, Syracuse, UT 84075

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my child or wards protected health information. I understand that the information can be used, but are not excluded to:

CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMOUNG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INCLUDED IN THAT TREATMENT DIRECTLY AND IN-DIRECTLY.

OBTAIN PAYMENT FROM THIRD-PARTY PAYERS.

CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY ASSESSMENTS AND PHYSICIAN CERTIFICATIONS.

I understand your Notice of Privacy Practices containing a more completed discretion of the uses and disclosures of my health information can be obtained if requested. I understand that this organization has the right to change the Notice of Privacy Practice from time to time and I may contact this organization at any time at the address above to obtain a current copy of Notice of Privacy Practices. I understand that I may request in writing that you restrict how my privacy information is used and disclose to carry out treatment, payment or health care operation. I also understand Kids Town Pediatric Dentistry is not required to agree to my restriction, but if you do agree then you are bound to abide by such restrictions.

_____ _____

Signature of Parent or Legal Guardian Date