NEW PATIENT FORM

Date: _____

Whom may we thank for referring you to us: _____

KENT ISLAND PEDIATRIC DENTISTRY

YOUR CHILD

Child's Name: _____ Nickname: _____ ☐ Male ☐ Female
last first mi

Date of Birth: _____ Age: _____ School: _____ Grade: _____

Child's Address: _____ City: _____ State: _____ Zip: _____

Who is accompanying child today: _____ Relationship: _____

Names and ages of other children in family:

RESPONSIBLE PARTY

Name: _____ Relationship: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Home : ( ) _____ Work: ( ) _____ Cell: ( ) _____

Who is responsible for making appointments: _____

PARENT or GUARDIAN INFORMATION

☐ Check here if this information is the same as above under "Responsible Party"

Name: _____ Relationship: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Email: _____ Home : ( ) _____ Work: ( ) _____ Cell: ( ) _____

Employer: _____ Occupation: _____ Marital Status: _____

PREFERRED METHOD TO CONFIRM YOUR CHILD'S APPOINTMENT

☐ Phone Call ☐ Text Message ☐ E-Mail

Please list the phone number or e-mail address you would like us to use: _____

EMERGENCY CONTACT

Name: _____ Address: _____

Relationship: _____ Home : ( ) _____ Work: ( ) _____ Cell: ( ) _____

PRIMARY DENTAL INSURANCE

Insured's name: _____ DOB: _____ Relationship: _____

Employer: _____ Occupation: _____ Date Employed: _____

Insurance Co: _____ Group No: _____ Employee No: _____

Ins Co Address: _____ City: _____ State: _____ Zip: _____

ADDITIONAL DENTAL INSURANCE

Insured's name: _____ DOB: _____ Relationship: _____

Employer: _____ Occupation: _____ Date Employed: _____

Insurance Co: _____ Group No: _____ Employee No: _____

Ins Co Address: _____ City: _____ State: _____ Zip: _____

Has your child ever had any of the following?

YES	NO		YES	NO		YES	NO	
☐	☐	AIDS / HIV	☐	☐	Developmental Delay	☐	☐	Pneumonia
☐	☐	Attention Deficit/Hyperactivity	☐	☐	Diabetes	☐	☐	Pregnancy
☐	☐	Anemia	☐	☐	Drug/Alcohol Abuse	☐	☐	Psychiatric Disorder
☐	☐	Allergy	☐	☐	Epilepsy	☐	☐	Rheumatic Fever
☐	☐	Asthma	☐	☐	Endocrine/Growth Disorders	☐	☐	Scarlet Fever
☐	☐	Autism	☐	☐	Eye Problems	☐	☐	Scoliosis
☐	☐	Bleeding Abnormalities	☐	☐	Fainting/Dizziness	☐	☐	Sickle Cell Anemia
☐	☐	Brain Injury	☐	☐	Hearing Loss	☐	☐	Sinus Problems/Snoring
☐	☐	Bronchitis	☐	☐	Heart Disease/Murmur	☐	☐	Sore Throat (Frequent)
☐	☐	Cancer	☐	☐	Hemophilia	☐	☐	Enlarged Tonsils/Adenoids
☐	☐	Cerebral Palsy	☐	☐	Hepatitis	☐	☐	Spina Bifida
☐	☐	Chicken Pox	☐	☐	Jaundice	☐	☐	Tuberculosis
☐	☐	Cleft Lip/Palate	☐	☐	Leukemia	OTHER:		
☐	☐	Communicable Disease	☐	☐	Measles	☐	☐	_____
☐	☐	Convulsions / Seizures	☐	☐	Mumps	☐	☐	_____

Please explain any checked items:

_____

_____

_____

☐ This child has never been diagnosed with any of the above conditions

How often does your child brush? _____ Floss? _____

Is brushing/flossing supervised? ☐Yes ☐No By Whom? _____

Is child's water fluoridated? ☐Yes ☐No ☐Don't Know

Is your child receiving fluoride supplements? ☐Yes ☐No

☐Tablets ☐Drops Dose: _____

Is this your child's first dental visit? ☐Yes ☐No

Previous Dentist & City: _____

Date of last visit: _____ Date of last dental xrays: _____

Any injuries to your child's teeth or jaw? ☐Yes ☐No

When/What? _____

Has your child had recent dental pain? ☐Yes ☐No

Explain: _____

☐ Breast feeding (until age) ☐ Bottle (until age)

☐ Thumb/finger sucking ☐ Pacifier ☐ Nail biting

☐ Dental grinding/clenching ☐ Mouthbreathing/snoring

Has your child experienced any unfavorable reaction from previous medical or dental care? ☐Yes ☐No

Explain: _____

_____

_____

Child's Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Date of last exam (list results): _____

List any medical problems, hospitalizations, surgeries the child has had: _____

_____

List all medications the child is currently taking (give reasons): _____

Premedication prior to dental treatment? ☐ Yes ☐No Why? _____

Is your child under the care of a specialist? ☐Yes ☐No Why? _____

Specialist's Name: _____ Phone: _____

Does your child have a physical or medical disability/delay? ☐ Yes ☐No Please Describe: _____

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications? ☐ Yes ☐No

If yes, please describe: _____

Does your child have a history of allergies to any other substances (latex, environmental, etc.)? ☐ Yes ☐No

If yes, please describe: _____

Is the child up to date on immunizations? ☐Yes ☐No Do you wish to speak to the doctor privately about a special concern? ☐ Yes ☐No

AUTHORIZATION & RELEASE

To the best of my knowledge, the questions on this form have been accurately answered I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental staff to perform the necessary dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist or dentist's group insurance benefits otherwise payable to me. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

_____ _____

Signature of Patient (or Parent/Guardian if minor) Date

Dentist's Review

_____ _____

Signature of Dentist Date

KENT ISLAND PEDIATRIC DENTISTRY

CANCELLATION and MISSED APPOINTMENT POLICY:

We request 48 business hours notice to reschedule an appointment. We strive to provide the highest quality dental care for your child. This involves reserving the proper amount of time to dedicate to your child. We understand that situations occur that may prevent proper notice.

Additionally, after 1 cancellation without proper notice or missed appointments, one may be dismissed from the practice.

We apologize for such tough policies, but we are a small business and wish to set standards that make it possible to provide the highest quality of care.

FINANCIAL POLICY

Payment for care is due at the time services are rendered. We accept cash, check and for your convenience MasterCard, Visa and American Express. With extensive treatment plans Care Credit and payment plans are available.

Please be aware that the parent bringing the child to our office is legally responsible for payment of all charges. We cannot send statements to other persons.

INSURANCE POLICY:

We DO participate with a number of insurance plans. We will accept assignment of benefits for those plans we participate.

If we do not participate with your plan, we will submit the statement to the insurance company for you as a courtesy if your plan allows. Payment for the estimated portion of services is due the day of treatment.

Remember insurance plans do NOT cover the full cost of most procedures. We can attempt to estimate benefits prior to any treatment, but this is a courtesy and just an estimate. Ultimately the insurance company and the plan your employer selected will determine your reimbursement. The dentist is NOT a party to your insurance contract and has no control over reimbursements. Think of your dental insurance as a coupon towards each visit. We will do all we can to help maximize your benefits.

Past Due Accounts:

Balances remaining unpaid at 30 days are subject to late payment charges of 1.5% per month, plus collection cost and attorney fees. Returned checks will be subject to a returned check fee.

I agree to the above office policies: _____ **Date**_____

PARENT/GUARDIAN SIGNATURE

160 Sallitt Drive Suite 106
Stevensville, MD 21666
Phone: (410) 604-2211
Fax: (410) 604-2744

Notice of Privacy Practices and Patient Consent
For Use and Disclosure of Protected Health Information

Patient Name: _____Date: _____

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain Patient Rights regarding my protected health information.

I understand that Kent Island Pediatric Dentistry may use or disclose my protected health information for treatment, payment or health care operations-which means for providing health care to me, the patient; handling billing and payment; and, taking care of other health care operations. Unless required by law, there will be no other uses and disclosures of this information without my authorization.

Kent Island Pediatric Dentistry has a detailed document called the **'Notice of Privacy Practices'**. It contains a more complete description of your rights to privacy and how we may use and disclose protected health information.

I understand that I have the right to read the 'Notice' before signing this agreement. If I ask, Kent Island Pediatric Dentistry will provide me with the most current *Notice of Privacy Practices*.

My signature below indicates that I have been given the chance to review such a copy of the *Notice of Privacy Practices.* My signature means that I agree to allow Kent Island Pediatric Dentistry to use and disclose my protected health information to carry out treatment, payment, and health care operations. I have the right to revoke this consent in writing at any time, except to the extent that Kent Island Pediatric Dentistry has taken action relying on this consent.

Signature (Parent or Legal Custodian/Authorized Representative)

_____

Date _____

Relationship to Patient (if signed by another party)_____

You may obtain a copy of our *Notice of Privacy Practice,* including any revisions of our '*Notice'* at any time by contacting: Kent Island Pediatric Dentistry (410) 604-2211