KidsGrins Pediatric Dentistry Patient Registration & Health History

Please complete the information below. This information is confidential and will not be shared without consent.

Child's Name M ( ) F ( ) Nickname
Last First M.I.

Date of Birth How did you hear about our office?

Address City Zip

Home Phone Email Address

Mother/Guardian Name		Father/Guardian Name	
Date of Birth	SS#	Date of Birth	SS#
Cell Phone	Work Phone	Cell Phone	Work Phone

Child lives with (circle) Mother Father Both Other:

Emergency Phone of a relative not listed above:

Previous Dentist (if any): Child's DOCTOR: DR. PHONE:

Has child had any history or problems with any of the following (PLEASE CIRCLE):

Anemia/Blood Disorder	Chicken Pox	Epilepsy	HIV/AIDS	Malignancies	Penicillin Allergy
Asthma	Chronic Sinus	Fainting	Immune Disorder	Measles	Seizures
Bladder	Convulsions	Glands	Kidney	Mononucleosis	Thyroid
Blindness	Diabetes	Hearing	Latex Allergy	Mumps	Transplant
Cerebral Palsy	Digestion	Heart	Liver	Rheumatic Fever	Tuberculosis
Developmental:	Autistic	ADD/ADHD	Downs Syndrome	Other: _____	

Please List Any ALLERGIES:

Details on Medical Conditions or Hospitalizations:

CURRENT MEDICATIONS:

How would you describe your child's temperament?

Has there ever been any injury to child's teeth or mouth?

Has your child ever had any unfavorable reaction to local or general anesthesia?

Child's Interests/Hobbies/Talents, etc:

CONSENT TO TREAT & HIPAA Consent For Use & Disclosure of Health Information:

By signing this form, you will consent to our use and disclosure of your child's protected health information to carry out treatment, payment activities and healthcare operations. You acknowledge that you have received and agree to our Notice of Privacy Practices with regard to this information. You have the right to revoke this Consent at any time by giving us written notice of your revocation.

I understand by signing this consent form, I am giving my consent to your use and disclosure of protected health information to carry out treatment, payment activities and health care operations.

I hereby give consent to perform dental services to my child. I will be informed of proposed procedures and agree to exams and x-rays as needed to diagnose dental conditions and necessary treatment. I also certify that the information I provided on this form is true and accurate to the best of my knowledge.

X

Signature **Printed Name** **Date**

Insurance Verification, Payment Policies & Consent Form

Primary Insurance Co. Name	**Secondary Insurance Co. Name**
Insurance Phone Number	Insurance Phone Number
Subscriber Name	Subscriber Name
Subscriber Date of Birth	Subscriber Date of Birth
Subscriber SS#	Subscriber SS#
Other ID#	Other ID#
Group#/Employer Name	Group#/Employer Name

ABOUT OUR PAYMENT POLICIES AND YOUR DENTAL INSURANCE PLAN

We are committed to providing your child with the best possible care. If you have dental insurance, we are anxious to help you maximize your benefits by reducing our regular rates. Although we may be contracted with your dental plan, most dental insurance companies pay only a *portion* of the services we provide. The amount that you are responsible to pay varies depending on your group/employer's contract with that company. We agree to bill your insurance company for all services rendered. However, your *estimated portion* , including co-insurance or deductibles, is due at the time services are rendered. The amount we collect is an estimate only, as the insurance company may not pay according to the guidelines they give us. Please realize that we are not responsible for the benefits your insurance company provides you. *Not all services are covered benefits and some insurance companies arbitrarily select certain services they will deny. You will be billed for any services that your insurance company denies or otherwise pays at a lesser amount than expected. Billing statements must be paid within 30 days of the billing date to avoid late charges or collections fees.*

Payments for services can be made with cash, checks and all major credit cards. Returned checks are subject to additional fees and may be reported to the Attorney General's Office. Charges may be made for broken appointments not canceled within 24 hours notice (48 hours for certain sedation appointments). If your child has an extensive treatment plan, you may apply for Care Credit Healthcare Financing.

If you have any questions about this payment policy, please don't hesitate to ask us. We are here to help in any way we can.

INSURANCE & PAYMENT POLICY CONSENT:

I authorize Kids Grins to request insurance benefit information for my child and to submit dental insurance claims on my behalf for any treatment rendered to my child. I understand that I am responsible for ALL fees, regardless of insurance coverage. I acknowledge that the insurance company does not guarantee payment to this office. I understand that although I will be given an estimate for any out-of-pocket costs, these costs are subject to change if treatment changes or insurance benefits change. I agree to pay my co-insurance and deductibles at the time services are rendered, and to pay any balance not paid by my insurance company within 30 days of the billing date.

X

Signature	**Printed Name**	**Date**

(For Office Use Only)

Date Verified: _____ By: _____ Mailing Address

Effective Date: _____ Renewal: Calendar / Fiscal _____

Deductible $ _____ /_____ Waiting Periods _____ _____

Annual Maximum $ _____ Maximum Available $_____ Elec Payor ID: _____

Preventive_____ % Apply deductible? Yes / No Spacers _____%

#Per Year / Limitations: Prophys:_____ FL2:_____ BWX:_____ FMX/PANO:_____

Exams: _____ Periapicals/Occlusals: _____ Sealants:_____ Other: _____

Basic _____% Perio _____% Endo _____% Oral Surgery _____%

Major _____% SS Crowns _____% Nitrous _____% Posterior Composites Downgraded? YES / NO

D2391: D2392: D2393: