Last Name:_____

First name(s):_____

_____

Welcome To Our Office!

We are delighted that you've chosen **Kids Dental Center** to take care of your child's dental needs. Please take a moment to answer the following questions as it will help us better serve you.

1. Where did you hear about us?

   ☐ Yellow Pages ☐ DEX ☐Insurance ☐Interenet search ☐Google/Yahoo search
   ☐Harkins Theatres ☐ SanTan News ☐ School ☐Value Pack ☐TV ☐ DR./Dentist
   ☐ Radio ☐ Super Coups ☐ Money mailer ☐ Saguaro Gold ☐ Other ☐ Friend

   If you checked Other, Friend, or DR./Dentist, please specify: _____

   _____

2. Why did you choose us?_____

   _____

3. What helped you decide to come in? (i.e. Ad, pain, friend, etc.)_____

   _____

4. If there is anything your child dislikes about going to the dentist, what is it?_____

   _____

5. Is there anything your child likes about going to the dentist?_____

Thank you very much for taking time to answer these questions. And once again, welcome to **Kids Dental Center**. We are delighted to have you and your child in our practice and look forward to serving you!

KIDS DENTAL CENTER

Patient Information

Name_____ _____ ☐ ☐ _____ _____
Last First M.I. Nickname Male Female Birthdate S.S.#
Home Address_____ _____ _____ _____ Hm.# _____
(If Different From Parent) City State Zip

Parent Information (Guarantor)

Name_____
Last First M.I.

☐ ☐ | ☐ ☐ ☐ | _____
Male Female | Single Married Other | Birthdate

_____–_____–_____ _____
S.S.# Driver's License #

_____
Street Address

_____ _____
City & State Zip

_____ _____
Home Phone/ Best Time? Pager or Mobile

_____ _____
Employer Street Address

_____ _____ _____
City & State Zip Work Phone/ Ext.

Other Parent

Name_____
Last First M.I.

☐ ☐ | ☐ ☐ ☐ | _____
Male Female | Single Married Other | Birthdate

_____–_____–_____ _____
S.S.# Driver's License #

_____
Street Address

_____ _____
City & State Zip

_____ _____
Home Phone/ Best Time? Pager or Mobile

_____ _____
Employer Street Address

_____ _____ _____
City & State Zip Work Phone/ Ext.

Emergency Information

Name of nearest relative not living with you_____ Phone#_____

Complete Address_____Relation to Patient_____

Dental Insurance Information

Primary Insured's Name_____Relation to Patient_____

Insured's S.S.#_____–_____–_____ InsuranceCompany_____GroupNo._____

Insurance Company Address_____Insurance Phone#_____

Do you have dual coverage? ☐ Yes ☐ No If Yes: Insured's Name_____

Relation to Patient_____ Insured's S.S.#_____–_____–_____

Insurance Company_____Group No._____Insurance Phone#_____

(480) 782- 5437(KIDS) Fax: (480) 857-7888

Patient History

Reason for today's visit? ☐ Emergency ☐ Cavity ☐ Examination ☐ Ortho Consult ☐ Concern
Please Explain:_____

Previous Dentist:_____Last Visit:_____X-rays taken:_____if yes, When:_____

Has the child ever had a serious/ difficult problem associated with previous dental work? If yes, please explain:_____
_____

Has the child ever had any injuries to mouth, teeth or head?_____

- Is he/she doing well in school? ☐ Yes ☐ No
- Does he/she get along w/others? ☐ Yes ☐ No
- Does the child brush teeth daily? ☐ Yes ☐ No
- Does the child floss teeth daily? ☐ Yes ☐ No
- Is the child taking fluoridated supplements? ☐ Yes ☐ No
- Has the child ever had any pain/tenderness in the jaw joint? ☐ Yes ☐ No

Circle any of the following which applies to your child:

- Nursing
- Bottle use
- Sippy cup
- Pacifier use
- Wets bed
- Bad temper
- Thumb/ finger sucking
- Speech problems
- Nail biting
- Tongue thrust
- Mouth breathing
- Tooth Grinding

_____

Medical History

Is the child currently under the care of a Physician? If yes, please explain:_____
_____

Child's Physician:_____Phone #_____Date of last visit:_____

Has your child ever had surgery or General Anesthesia?_____

Are test and Immunizations (DPT, diptheria, tetanus, whooping cough, measles and polio, vaccines) up to date? ☐ Yes ☐ No
Please explain:_____ Has he/she had a skin test for tuberculosis? ☐ Yes ☐ No

Is your child currently taking any **MEDICATION**? If yes, please list_____
_____

IS YOUR CHILD **ALLERGIC TO ANY MEDICINE, FOOD OR MATERIALS** (**including LATEX**)? If yes, please explain:_____

Does your child have any history of the following **MEDICAL PROBLEMS**? (Please Circle)

- Abnormal Bleeding
- ADD/ADHD
  Attention Deficit Disorder/
  Attention Deficit Hyperactivity Disorder
- Allergic to Local Anesthesia
  (Novocaine)
- Allergies to any Drugs
- Anemia
- Asthma
- Blood Transfusion
- Cancer/ Tumor
- Congenital Heart Defect
- Convulsions
- Diabetes
- Developmentally Delayed
  Age Level patient is at_____
- Ear Infections
- Epilepsy
- Exposed to HIV
  (But Negative)
- Eye Problems
- Handicaps/ Disabilities
- Hearing Impairment
- Heart Murmur
- Hemophilia
- Hepatitis
- High Blood Pressure
- HIV +/ AIDS
- Kidney/ Liver Problems
- Lung Disease
- Rheumatic/ Scarlet Fever
- Skin Rash
- Tuberculosis (TB)
- Women: are you pregnant?

If circled, please explain:_____
_____

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____
Signature of Parent or Guardia ***Date***

Dr. notes and signature

KIDS DENTAL CENTER *Pediatric Specialist*
2900 W. Ray Rd. Ste. 2, Chandler, Az. 85224 (480)782-5437(KIDS) FAX:(480) 857-7888

CHILD POLICY STATEMENT
(For ages 3- 9)

Kids welcome to our office. Our policy is to have fun *at all* times and to make sure you have more fun! Please sign below and bring this to the office! Thanks so much for your help.
Looking forward in meeting you soon.

_____ _____

Childs Signature Date

KIDS DENTAL CENTER
2900 Ray Rd., Ste. # 2, Chandler, Az. 85224 Ph.: (480) 782-5437 Fax: (480) 857-7888

Notice of Patient Privacy Protection

We understand that medical information about you is important and personal, and we are committed to protecting it. In accordance with the guidelines issued by the Department of Health and Human Services regarding privacy protections for dental records and personal health information. The following describes the type of uses and disclosures that require your signature. Kids Dental Center complies in the following manner:

1. As a patient, portions of your records may be released to other health/dental care providers to assist with your care. Your records may be released to your insurance carrier for billing purposes or to obtain preauthorization's for dental treatment.
2. A separate authorization must be obtained from you before records and copies of radiographs are released/transferred to another dentist. Due to time and material involved, there is a $15.00 fee for the first patient, and $5.00 for each additional patient. You have the right to request restrictions on release of information. **By law we keep all the original X-Rays, you may ask us for the AZ law declaring this.**
3. The only people with access to your records are the staff and Dr.'s at Kids Dental Center. If you feel that privacy protections have been violated by our office, you have the right to file a complaint with our office, your insurance carrier or the Department of Health and Human Services.
4. Our open bay treatment design prevents the doctors and staff from discussing your treatment or your child's treatment privately. If you do wish to keep the treatment private from other people, please inform the doctor and the staff and we will provide a private room to do so.
5. Other uses and disclosures not described in the NPP will be made only with the patient's written authorization.
6. Patient may revoke an authorization at any time, as long as the patient does so in writing.
7. Our office does not have to agree if a patient asks us not to use or disclose the patient's info in a certain way, except if the following 2 criteria are met:

- If the patient asks the dental practice not to disclose info about a dental care item or service to a heath plan for payment or heath care operations purposes, and
- The dental practice has been paid in full for the service by the patient or on behalf of the patient.

8. The practice is required by law to notify affected individuals following a breach of unsecured patient info.
9. The practice cannot sell patient info without the patient's express written authorization.

I understand the above privacy protection compliance statement and authorize release of my dental records only to my Healthcare/Dental provider and/or Dental insurance carrier within the normal course of my treatment.
I also acknowledge receiving a copy of the Privacy Practices Information given to me by Kids Dental Center.

_____ _____

Parent/Guardian/ Patient Signature Date