Thank you for visiting our office. We are committed to providing excellence in oral and dental health care for children in a tender loving care environment. Please take a moment to fill out these forms so that we can serve you in the best manner.

## Tell Us About Your Child

Today's Date: ____________________

Child's Name:

LAST ____________________

FIRST ____________________ MI ________

NICKNAME ____________________ ☐ MALE ☐ FEMALE

Child's Birthdate: _____ / _____ / _____ Child's Age: ________

School: ____________________ Grade: ________

Child's Home Phone: ( _______ ) ____________________

Child's Home Address:

STREET ____________________

CITY ____________________

STATE ____________________ ZIP ________

Please list sibling names and ages living in the same home:

FIRST: ____________________ AGE: ________

FIRST: ____________________ AGE: ________

FIRST: ____________________ AGE: ________

FIRST: ____________________ AGE: ________

**To whom may we thank for referring you to our office?**

____________________

## Mother's Information

☐ STEPMOTHER ☐ GUARDIAN ☐ RESPONSIBLE PARTY

☐ MISS ☐ MS ☐ MRS ☐ DR Birthdate: _____ / _____ / _____

Name: ____________________

Home Phone: ( _______ ) ____________________

Cell Phone: ( _______ ) ____________________

Address: ☐ SAME AS CHILD'S

STREET ____________________

CITY ____________________

STATE ____________________ ZIP ________

EMAIL ____________________

Employer: ____________________

Occupation: ____________________ SSN: _____ / _____ / _____

Work Phone: ( _______ ) ____________________ EXT ________

## Father's Information

☐ STEPFATHER ☐ GUARDIAN ☐ RESPONSIBLE PARTY

☐ MR ☐ DR Birthdate: _____ / _____ / _____

Name: ____________________

Home Phone: ( _______ ) ____________________

Cell Phone: ( _______ ) ____________________

Address: ☐ SAME AS CHILD'S

STREET ____________________

CITY ____________________

STATE ____________________ ZIP ________

EMAIL ____________________

Employer: ____________________

Occupation: ____________________ SSN: _____ / _____ / _____

Work Phone: ( _______ ) ____________________ EXT ________

## Dental Insurance Information

Name of Policy Holder: ____________________

Relationship to Patient: ____________________

Policy Holder's Birthdate: _____ / _____ / _____

Policy Number (or SSN): ____________________

Group Number: ____________________

Dental Insurance Provider: ____________________

Dental Insurance Address:

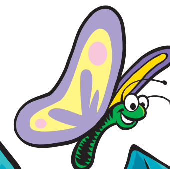
STREET ____________________

CITY ____________________

STATE ____________________ ZIP ________

Dental Insurance Phone: ( _______ ) ____________________

**Please advise our office if you carry more than one dental policy.**



# OFFICE POLICIES

Thank you for choosing our office for your child's oral and dental health needs. We look forward to a long and happy relationship. Please take a moment to read this form and then initial each to the left where indicated. The goal of this agreement is to help you to better understand how our office works.

## Please initial each paragraph acknowledging our policies

_____ I understand that a parent or legal guardian will accompany my child to each visit, or I will make available contact numbers where I can be reached during that visit.

_____ I will arrive 5 minutes prior to each visit, and will allow more time if changes to my account need to be made. I understand that, if I am late, my appointment will need to be rescheduled.

_____ If adjustments to my appointment need to be made, I will contact the office at least 24 hours in advance.

_____ I understand that payment is expected at each appointment. If my family has insurance that **Kids Teeth LLC** participates with, I authorize payment to go directly to the office. I know efforts to determine my co-payment in advance will be made. For insurances that **Kids Teeth LLC** do not participate with, payment is due when services are rendered. Ultimately I am responsible for my full balance.

_____ If any changes occur to my family's health, home phone numbers, address or insurance status, it is my responsibility to make **Kids Teeth LLC** aware of it as soon as possible.

## Certification

I certify that I have read and understand the policies above. I acknowledge that I have received and reviewed a copy of the HIPAA Privacy Act to allow **Kids Teeth LLC** to use my family's protected health information only to carry out treatment, payment activities and healthcare operations. Any other disclosure of my information will only be released with a written and signed authorization from a legal parent or guardian.

Signature: ____________________________________________

Date: ____________________________________________

## Consent

I authorize Doctors, and team members, of **Kids Teeth LLC** to perform the necessary dental services that my child may need. I understand that treatment will be discussed prior to having dental work performed. I will have the opportunity for discussion and questions at all times.

Signature: ____________________________________________

Date: ____________________________________________