Thank you for scheduling an appointment with our office.

We are committed to providing exceptional oral and dental health care for children in a safe, welcoming, and nurturing environment. Please take a moment to complete these forms so we can deliver the highest level of care tailored to your child's needs.

Patient information

Patient's First Name: _____ Last Name;_____

Date of Birth (DOB): ____ / ____ / _____

Preferred Name (Nickname): _____ Preferred pronoun: _____

Gender: ☐Male ☐Female

Home Address: _____

City: _____ State: _____ Zip: _____

Siblings (if applicable) First Name	Age/DOB
_____	_____
_____	_____
_____	_____

Parent / Guardian Information

Parent / Guardian #1

Full Name: _____

Relationship to Patient: _____

Is this person the Legal Guardian? ☐Yes ☐No

Is this person the Responsible Party? ☐Yes ☐No

Phone Number: _____

Email Address: _____

Address (if different from patient): _____

Parent / Guardian #2

Full Name: _____

Relationship to Patient: _____

Is this person the Legal Guardian? ☐Yes ☐No

Is this person the Responsible Party? ☐Yes ☐No

Phone Number: _____

Email Address: _____

Address (if different from patient): _____

Dental Insurance Information

Dental Insurance Provider: _____ 2ndary Plan_____

Insurance Contact Number: _____ " " _____

Policy Number: _____ " " _____

Policy Holder's Full Name: _____ " " _____

Policy Holder's Date of Birth: ____ / ____ / _____

Employer Name: _____ " " _____

Employer Phone Number: _____ " " _____

Office Policy Agreement

Thank you for choosing **Kids Teeth LLC** for your child's oral and dental health needs. We look forward to a long and happy relationship. Please take a moment to read and initial each of our office policies below.

☐I understand my child cannot be seen without a parent or legal guardian accompanying them in the office.

☐I will arrive 5–10 minutes prior to each visit to ensure all updates have been made to my account and/or insurance plans.

☐If I arrive late, I understand my appointment may be rescheduled. If I cancel without a 24-hour notice, both are subject to a fee.

☐I understand that if I have any changes to my insurance, I must notify the office. If I fail to do so and a claim is denied and unrecoverable, I am responsible for the full cost of the visit.

☐I understand that as a courtesy Kids Teeth LLC will file for secondary plans but is not responsible for any services they do not cover/pay.

☐All anticipated co-pays are expected to be paid at every visit.

Certification

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

Signature of Parent/Guardian: _____ **Date:** ____ / ____ / _____

Consent for Treatment

I authorize the doctors and team members of **Kids Teeth LLC** to perform the necessary dental services my child may need. I understand that treatment options will be discussed prior to any dental work being performed, and I will have the opportunity to ask questions and discuss concerns at any time.

Signature of Parent/Guardian: _____ **Date:** ____ / ____ / _____