About your child

Child's full name:

____

☐ male ☐ female

Date of birth _____________ age __________

How did you hear about us?

____

Dental History

Is this your child's first dental visit ☐ yes ☐ no

Previous dentist:

____

Date of last visit: ________________________

Any injuries to child's face or jaw?

____

History of:

Thumb sucking	☐ past	☐ present
Pacifier use	☐ past	☐ present
Teeth grinding/clenching	☐ past	☐ present

Other habits: ____________________________

Has your child had any unpleasant experiences or an unfavorable reaction to previous dental care? ☐ yes ☐ no

If yes, please explain:

____

____

Who is responsible for brushing child's teeth?

____

Brushing:	☐ AM	☐ PM	☐ Both
Flossing:	☐ AM	☐ PM	☐ Both

Fluoride and Dietary Assessment

Does your child use fluoride toothpaste?

☐ yes ☐ no

Does your child take prescription fluoride?

☐ yes ☐ no

Has your child had fluoride treatments before?

☐ yes ☐ no

Is your child a good eater? ☐ yes ☐ no

Does your child drink:

☐ juice ☐ milk ☐ soda ☐ energy drinks

Is your child breast feeding? ☐ yes ☐ no

Is your child using a bottle or sippy cup?

☐ yes ☐ no

Medical History

Does your child require antibiotics prior to dental treatment due to a heart defect or other medical conditions? ☐ yes ☐ no

Is your child allergic to latex, dyes or metals?

☐ yes ☐ no

List: ________________________________

Is your child allergic to any medications?

☐ yes ☐ no

Please list all allergies:

____

____

____

Is your child taking any medications?

☐ yes ☐ no

List: ________________________________

____

Pediatrician/physician: ______________________________

Phone: ______________________________

Date of last check up: ____________________

Does your child have, ever had, or been diagnosed with any of the following? Check ***all*** that apply.

__Anemia	__Autism	__Asthma/Triggers: ____________________	
__Bladder conditions	__Blood disorder/sickle cell	__Blood transfusion	__Birth defects
__Bone or joint problems	__Brain injury	__Bruising easily	__Child abuse
__Cancer or malignancies	__Cerebral palsy	__Chemotherapy or radiation	__Cleft lip/palate
__Chronic ear infections	__Chronic headaches	__Congenital heart defect	__Drug addiction
__Convulsions/Seizures	__Developmentally delayed	__Diabetes	__Excessive bleeding
__Emotional disturbance	__Epilepsy	__Eye problem	__Heart surgery
__Excessive gagging	__Fainting or dizziness	__Fever blister/cold sores	__Hemophilia
__Growth problems	__Hearing/speech impediment	__Heart murmur/defect	__Hyperactivity/ADHD
__Hepatitis or liver disease	__High blood pressure	__HIV	__Nutritional deficiency
__Kidney disease	__Leukemia	__Neurological problems	__Psychiatric care
__Orthopedic problems	__Pain in jaw joints	__Premature birth	__Sleep apnea/snoring
__Respiratory disease	__Rheumatic fever	__Sensory integration disorder	__Shunts

Is your child currently under the care of a physician or specialist for any reason? □ yes □ no

Reason for care: ____

If needed, please describe any checked items further:

____

____

____

____

Do you wish to speak with the doctor privately about special concerns? □ yes □ no

Does your child have any other condition not listed on this page? □ yes □ no

List: ____

Parent/Guardian Information

Policy Holder/Responsible Party:

____

Relationship to Patient:

____

Occupation:

____

Home Address:

____

____

City and zip code:______________________

DOB: __________________________

Work Phone:______________________

Cell Phone: ______________________

Work Phone: ______________________

Email: __________________________

□ Married □ Single □ Divorced □ Widowed

Second Responsible Party:

____

Relationship to Patient:

____

Occupation:

____

Home Address:

____

____

City and zip code:______________________

DOB: __________________________

Work Phone:______________________

Cell Phone: ______________________

Work Phone: ______________________

Email: __________________________

□ Married □ Single □ Divorced □ Widowed

Step parent:

____

Legal guardian:

____

Siblings:

____

Insurance Information

Insurance company and employer:

____

Subscriber/Policy holder's name:

____

Relationship to child:

____

Subscriber/Policy holder's DOB:

____

Subscriber/Policy holder's social security #:
(If your child has Colorado health OP, list their social security number).

____

ID#: __________________________

Group#: __________________________

Does this child have Medicaid? □ yes □ no

Medicaid#: __________________________

Secondary Insurance Information

Insurance company and employer:

____

Subscriber/Policy holder's name:

____

Relationship to child:

____

Subscriber/Policy holder's DOB:

____

Subscriber/ Policy holder's social security #:
(If your child has Colorado health OP, list their social security number).

____

ID #:__________________________

Group #: __________________________

Authorization

I understand that I am responsible for all charges incurred by me or my family regardless of insurance coverage and that payment is due at the time services are rendered. I hereby authorize payment directly to Littleton Kids Dental and Orthodontics from any insurance company listed above. I agree to the payment of any co-pays, deductibles, and uncovered services or amounts. I authorize the release of any dental information necessary to process insurance claims or for determination of benefits. If my account requires servicing for collection, I understand that I will be liable for all fees incurred.

Signature:__________________________

Today's date: __________________________

Vital information about your Dental Insurance

Insurance companies set their own schedules, and each company uses a different set of fees they consider allowable. When estimating dental benefits, deductibles and percentages must be considered. If we have received all of your insurance information and you have kept us current on any insurance changes, we will be happy to file the claim for you. Please be familiar with your insurance benefits, as this is a contract between you and the insurance company. At the time of service, we will collect from you the estimated portion that insurance is not expected to pay. By law your insurance is required to pay each claim within 30 days of receipt. We file insurance claims electronically, so your insurance company will receive each claim within days.

Cancellation policy

Cancellations require a 24 hour notice. We reserve the right to charge $25.00 per child for not giving such notice. While we understand that circumstances happen that can cause you to cancel, please understand that we cannot fill a cancelled spot last minute.

Consents for treatment and release of information

I give the doctor permission to use such measures as deemed necessary in his/her professional judgment to render a diagnosis for my child and to perform treatment. This would include an oral examination, radiographs (x-rays) and other diagnostic aids. I understand that dental treatments are meant to help save my child's teeth, but it is not guaranteed. When a treatment plan is put together, I understand that treatment may not go in order of the written plan. I understand treatment is done in the order that is best for the patient and that treatment may change if necessary once a procedure has started.

I have given an accurate report of my child's physical and mental health history. I have also reported any proper allergic or unusual reactions to drugs, food, skin or any other physical conditions that my child's medical doctor has advised me should be reported to the dentist.

I understand and consent to x-rays and other protected health information being sent via email for the purpose of referrals, treatment and collection from insurance.

Responsible party signature: ____ Date: ____________

TURN OVER

Acknowledgement of receipt of Notice of Privacy Practices

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative locations, you may complain to the U.S. Department of Health and Human Services.

I, ____ (check one of the following)

□ I have read and I have received a copy of this office's Notice of Privacy Practices

□ I have printed and signed a copy of this office's Notice of Privacy Practices from the Littleton

Kids Dental and Orthodontics website.

□ I have read this office's Notice of Privacy Practices and do not wish to have a copy.

Signature: ______________________________________ Date: ________________

-Below is for office use only-

□ Individual refused to sign □ Communication barriers prohibited obtaining acknowledgement

□ An emergency situation prevented us from obtaining acknowledgement □ Other (specify)

LATE APPOINTMENT AND CANCELLED APPOINTMENT POLICIES

LATE APPOINTMENT POLICY

Please arrive on time to your scheduled appointment. Late arrivals cause schedule delays for those patients who arrive promptly at their appointment time. Late arrivals will be worked into the schedule if time allows or **re-appointed to another day**.

CANCELLED APPOINTMENT POLICY

We ask that you make every effort to give us at least a **24-hour notice** if you cannot make your scheduled appointment. **If you are unable to give this notice, you will be charged $25.00 for the missed appointment.**

When you give us 24-hour notice, your reserved time can be made available for another patient. When patients do not show for their appointment or do not give us adequate cancellation notice, we are not given the opportunity to reschedule that time with another patient who has a true dental need.

Thank you for understanding the value of our cancellation policy to each of our patients.

I understand and agree to the late appointment and cancelled appointment policies.

______________________________   ________________

Signature   Date