Please Fill Out Form Completely & Accurately.

PATIENT INFORMATION

Child's Name _____

Nickname _____

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone # _____

Birthdate _____ Age _____ Male ___ Female ___

School _____

GETTING TO KNOW YOU

Is another member of your family a patient at our office?

Yes _____ No _____

If yes, name: _____

_____

Who may we thank for referring you to our office?

Name: _____

Doctor or Patient or Other

Please indicate the phone number you would like us to use to confirm appointments: _____

Phone

ACCOUNT INFORMATION

Person responsible for account: _____

Contact number other than home: _____

Please be sure all blanks are filled in.

INSURANCE INFORMATION

Primary Carrier: Mom _____ **Dad** _____

Insurance Company _____

Employee _____

Union or Local # _____ Group # _____

Insurance Phone # _____

Secondary Carrier: Mom _____ **Dad** _____

Insurance Company _____

Employee _____

Union or Local # _____ Group # _____

Insurance Phone # _____

PARENT INFORMATION

Mother's Information- Birthdate: _____

Name _____ S.S. # _____

Address _____ Phone _____

City _____ State _____ Zip _____

Occupation _____

Employer _____

Business Telephone _____ Ext. _____

Father's Information - Birthdate: _____

Name _____ S.S. # _____

Address _____ Phone _____

City _____ State _____ Zip _____

Occupation _____

Employer _____

Business Telephone _____ Ext. _____

Todays Date: _____

If you would like us to contact you through your e-mail address, please supply below:

_____

Patient's Name _____ Date of Birth _____ Date _____

Directions: Please circle appropriate answers and fill in blanks. If you don't know an answer circle "(?)".

MEDICAL HISTORY

Does the child have any history of the following?

Heart Problems or Murmur	YES	NO	(?)	Vision Problems	YES	NO	(?)
Rheumatic Fever	YES	NO	(?)	Asthma or Wheezing	YES	NO	(?)
Bleeding or Clotting Problems	YES	NO	(?)	Allergies or Hay Fever	YES	NO	(?)
Sickle Cell Anemia or Trait	YES	NO	(?)	Feeding or Eating Problems	YES	NO	(?)
Autism	YES	NO	(?)	Growth Problems	YES	NO	(?)
Asperger Syndrome	YES	NO	(?)	Cerebral Palsy	YES	NO	(?)
Obsessive Compulsive Disorder (OCD)	YES	NO	(?)	Ear or Hearing Problems	YES	NO	(?)
ADD or ADHD	YES	NO	(?)	Speech Difficulties	YES	NO	(?)
Cleft Lip or Palate	YES	NO	(?)	Hepatitis or Liver Disease	YES	NO	(?)
Birth Defects or Genetic Disorders	YES	NO	(?)	Diabetes	YES	NO	(?)
Seizure Disorders/Epilepsy	YES	NO	(?)	Tuberculosis	YES	NO	(?)
Developmental Delay	YES	NO	(?)	Kidney Problems	YES	NO	(?)
Down Syndrome	YES	NO	(?)	Other Medical Problems (specify)	YES	NO	(?)
Bone or Joint Problems	YES	NO	(?)				
HIV or AIDS	YES	NO	(?)				

Name of child's physician _____ Date of last visit _____

Address _____ Phone # _____

Is the child currently under the care of a physician?	YES	NO	(?)
If yes, for what condition? _____			
Is the child currently taking any medications?	YES	NO	(?)
If yes, list _____			
for what condition _____			
Has the child had an allergic or unfavorable reaction to any medications?	**YES**	**NO**	**(?)**
To what _____ Reaction _____			
Has the child ever been hospitalized?	YES	NO	(?)
Age _____ Reason _____			
Has the child been treated in the emergency room?	YES	NO	(?)
Age _____ Reason _____			
Is there any additional medical information about the child not reported above?	YES	NO	(?)
If yes, describe _____			

DENTAL HISTORY

Why is the child seeking dental care? ☐ Check Up ☐ Toothache ☐ Cavities ☐ Injury ☐ Other _____

Has the child been to a dentist before?	YES	NO	(?)
If yes, give date of last visit _____			
Has the child had any of the following dental problems?			
Injuries to mouth or teeth	YES	NO	(?)
Toothaches	YES	NO	(?)
Abscesses (gum boils)	YES	NO	(?)
Other (specify) _____	YES	NO	(?)
Does the child have any of the following habits?			
Finger or thumb sucking	YES	NO	(?)
Tooth grinding or clenching	YES	NO	(?)
Other (specify) _____	YES	NO	(?)
Does the child receive fluoride tablets, drops or vitamins with fluoride?	YES	NO	(?)
Does the child use a fluoride rinse at home or school?	YES	NO	(?)
Is there any additional dental information we should know?	YES	NO	(?)
If yes, describe _____			

SOCIAL & BEHAVIORAL HISTORY

Do you think the child will cooperate for dental treatment?	YES	NO	(?)
Has the child had a previous bad or fearful dental or medical experience?	YES	NO	(?)
Which of the following best describes the child?			
_____Advanced in the learning process _____Progressing normally _____ Slow learner			
Does the child have any history of emotional or behavioral problems?	YES	NO	(?)
If yes, describe _____			
Is there any additional information we should know?	YES	NO	(?)
If yes, comment _____			

Your child is a minor; therefore, it is necessary that signed permission be obtained from a parent or guardian before any dental care can begin.

I acknowledge that the above information is correct and grant this office permission to provide my child's dental and related medical/surgical treatment as deemed necessary, utilizing proper and acceptable methods used in the specialty of pediatric dentistry to complete same treatment, including diagnostic radiographs. If my child ever has a change in his/her health or his/her medications change, I will inform the doctor at the next appointment without fail.

_____ _____

Signature of parent or legal guardian Date

Dentist's remarks: _____

Kids' Dental Safari and Braces
2381 B. Renaissance Dr.
Las Vegas, Nevada 89119
(702) 786-6684

Patient Financial Responsibility

We are pleased to welcome your child as a new patient. To prevent any misunderstanding regarding payment for your child's treatment, please review and sign the following policy.

After the examination of your child is completed you will be given a printed summary of the projected treatment along with an **estimate** of the anticipated fees.

PATIENTS WITH INSURANCE:

For your child's first visit, if insurance cannot be verified, full cash payment is required at the time of services are rendered.

We will attempt to verify your dental insurance coverage at or before your first visit. We can file insurance claims as a courtesy to you. Please remember however, that you, the parent, are ultimately responsible for payment on the account, NOT your insurance company. You must pay your deductible, co-payment, and fees for service not covered, at the time treatment is provided. You are still responsible for these fees even if you have double insurance coverage. We do not routinely bill secondary insurance companies. This is the patient's responsibility.

We can only make estimates regarding insurance company payments based upon the information that is given to us at the time of verification.

While we do our best to collect all fees due from your insurance carrier, fees not paid by the carrier within 60 days are due and payable by the patient.

CASH PATIENTS:

Payment is due at the time of service. Any cash balance over 60 days is subject to a finance charge of 1 ½% per month. We offer "Care Credit" patient payment plans.

If your account remains unpaid past 90 days, it may be sent to a collection agency for non-payment and/or delinquent matters. All accounts sent to collections are subject to a collection agency fee and possibly other legal costs in addition to the balance that is owed. If you have any questions regarding this policy, please ask us.

The parent or guardian who accompanies the child is responsible for payment.

I have read and understand the contents of this agreement. I agree to comply with all policies.
Patient's name _____

Signed: _____

Parent's Name _____
(Please print name)

Date: _____

Kids' Dental Safari and Braces
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Las Vegas, Nevada 89119

Privacy Rule Patient Consent Agreement
Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (164.506(a))

I, _____ understand that as a part of my health care, Kids' Dental Safari and Braces (KDS) originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment and any plans for future care or treatment. I understand that this information serves as:

- Basis for planning my care and treatment;
- A means of communication among the health professionals who may contribute to my health care;
- A means by which a third-party payer can verify that services billed were actually provided;
- A tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals;

I have been provided with a copy and understand the **Notice of Information Practices** that provides a more complete description of information uses and disclosures.

I understand that:

- I have the right to review KDS Notice of Information practices prior to signing this consent;
- That KDS reserves the right to change the notice and practices and that prior to implementation will mail a copy of any revised notice to the address I've provided if requested;
- I have the right to request restrictions as to how my protected health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that KDS is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that KDS has already take action in reliance thereon;

I requested the following restrictions to the use or disclosure of my protected health information:

_____ Accepted _____ Denied

Signature of Parent or Legal Representative Witness _____

Printed Name of Patient or Legal Representative Witness _____

Date: _____

INFORMATION ON MANAGEMENT OF BEHAVIOR

Our desire is to provide quality treatment in a caring environment for you and your child. We provide the following information in order to familiarize you with our office policies. Please feel free to discuss any questions you may have with a member of our staff.

We ask that parents accompany their child back to the examination room for their first visit. A complete diagnosis and any necessary x-rays will be completed. **The doctor will discuss his/her diagnosis and recommend a plan of treatment. On subsequent visits, we ask the parents to remain in the reception area and your child will be taken to the treatment area alone.** We have found that we are better able to establish a rapport and keep all of our attention focused on the child when the parent is not present. One of our dental assistants will remain with your child at all times. When treatment has been completed the dentist or dental assistant will explain to you what was done, as well as what the next treatment will involve. At any visit if you wish to speak to the dentist about anything, please tell the dental assistant and the doctor will be happy to meet with you.

We utilize a number of behavior management techniques to help children through their treatment. All of the techniques we use are recognized by the American Academy of Pediatric Dentistry as effective and acceptable. Our goal is to provide the treatment in an efficient, safe manner while hopefully instilling a positive dental attitude in the child.

During treatment, nitrous oxide (laughing gas) is frequently used to reduce anxiety. (We call the small rubber mask "Mr. Nose".) Nitrous oxide is very safe, has few side effects with the exception of nausea in a small percentage of children, and has no lingering effects after the visit. For our especially fearful patients, the doctors may suggest that your child be given a mild sedative prior to treatment. This premedication is generally liquid Demerol and Atarax given orally one hour prior to the appointment as a sedative and relaxant. Our goal is not to put your child to sleep; rather, to help relax them and make him or her feel happy and more comfortable with the visit.

In order to provide quality dental work and reduce the risk of injury to a child, it is absolutely necessary that the child remain still during treatment. Despite our efforts to calm a child with reassurances, showing the instruments and explaining the noises they will hear, at times we encounter difficult management problems. If a child is cooperating poorly it may be necessary to use one or more of the following behavioral management techniques to facilitate treatment.

VOICE CONTROL: In order to gain the child's attention, instruction is given in a firm tone of voice.

IMMOBILIZATION: So the child does not cause injury to themselves by trying to grab the doctor's hand during treatment, some children may need to have their hands held by an assistant during certain parts of the procedure to help them sit still. If a child is too young to understand the importance of sitting still (usually 3 years of age or less) or if they are endangering themselves with a lot of uncontrolled movement, they may need to be placed in a pediatric wrap which is sometimes referred to as a "papoose board". The wrap or papoose board holds the head and wraps the arms and legs securely in a blanket fastened with Velcro closures. This is used as a last resort in order to provide motion control so your child is protected during the dental procedures. It is not used as punishment. In the event we feel the wrap must be used, we will notify you at that time, before, placing the child in the wrap. You will have the option to giving or denying us permission to use the wrap. If you decline the use of the papoose board it will likely mean that no further treatment can be rendered that day and it may then be necessary to consider hospitalization for future treatment.

HOSPITALIZATION: This may be recommended for very young children or those children with significant medical or behavioral problems. This is required for very few children and will be thoroughly discussed with you if other options cannot be used successfully.

Your child's best interests are the most important to us. We will seek to conservatively manage the behavior of your child and help him or her to accept dental care in a positive, non-threatening environment. We hope to promote good, long-term attitudes toward dentistry, oral health, and self. Thank you for trusting us to treat your child.

CONSENT FOR TREATMENT

1. I, hereby authorize and direct Kids' Dental Safari and Braces to perform on my child necessary dental treatment as presented in the treatment plan, including the use of necessary or advisable local anesthesia, radiographs (x-rays), diagnostic aids, and/or nitrous oxide.
2. I, have read the preceding information regarding behavior management techniques and understand that at times it may be necessary for the dentist to utilize these management techniques; I can discuss them with the dentist prior to treatment.
3. I, understand that specific dental/surgical procedures will be explained when I am presented his or her treatment plan. Alternate methods, if any will also be explained to me, as will the advantages and disadvantages of each. I, am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and, therefore, can be no guarantee, expressed or implied, as to the result of the treatment or as to cure.
4. Although their occurrence is infrequent, there are some inherent risks that accompany dental procedures.
    a. Local anesthetic (such as Lidocaine or Novacaine) is used to make teeth numb so that dental treatment will not hurt. When it is used, the child may chew the cheek, lip or tongue while they are numb. Soreness of the lower jaw (trismus) may also occur.
    b. Although not common, excessive bleeding, pain or swelling may occur following the removal of a tooth. Temporary or permanent numbness of the tongue or lip (paresthesia) can also occur.
    c. Nitrous oxide (laughing gas) is used to help relax children who are particularly nervous so that the treatment can be done properly. Though infrequent, the child may experience nausea or vomiting with its use.

I, hereby state that I have read and understand this consent, and that all questions about the procedure(s) have been answered to my satisfaction. I understand that I have the right to be provided with answer to questions that may arise during the course of my child's treatment.

I, also further understand that this consent will remain in effect until such time that I choose to terminate it.

Patient's name _____Date _____ Time _____

Signature of Parent or Guardian: _____

Relationship to Patient _____

Witness: _____