Tell Us About Your Child

Today's Date: _____

Child's Name: _____
Last First MI

☐ Male ☐ Female

Child's Birthdate: _____ Child's Age: _____

School: _____ Grade: _____

Child's Home #: ( ) _____ SS#: _____

Parent Email Address _____

Who Is Accompanying The Child Today?

Name: _____ Relation: _____

Do you have legal custody of this child? ☐ Yes ☐ No

Whom may we thank for referring you? _____

Has this child been to Kid's Dental Center previously? ☐ Yes ☐ No

Other family members seen by us? _____

Previous/Present Dentist: _____

Last Visit Date: _____

Parent's Marital Status: ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Mother's Information:

☐ Biological Mother ☐ Adopted Mother ☐ Step Mother ☐ Guardian

Name: _____ Birthdate: _____

Home #: _____ Cell #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Employer: _____

Work #: _____

SS #: _____

Driver's License No. _____ Exp: _____

1805 Keith Street NW, Cleveland, TN, 37311 ~ (423) 458-4147

Father's Information:

☐ Biological Father ☐ Adopted Father ☐ Step Father ☐ Guardian

Name: _____ Birthdate: _____

Home #: _____ Cell #: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Occupation: _____

Employer: _____

Work #: _____

SS #: _____

Driver's License No. _____ Exp: _____

Person(s) with Consent to Bring My Child to Appointments:

Name: _____ Relation: _____

Name: _____ Relation: _____

Emergency Contact:

Name: _____ Relation: _____

Address: _____

Phone: _____

Primary Dental Insurance

Insurance Co. Name: _____

Insurance Co. Phone #: _____

Insurance Policy ID #: _____

Group # _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/_____ SS#: _____

Policy Owner's Employer: _____

Orthodontic Coverage? ☐ Yes ☐ No

Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Phone #: _____

Insurance Policy ID #: _____

Group # _____

Policy Owner's Name: _____

Relationship to Patient: _____

Policy Owner's Birthdate: ____/____/_____ SS #: _____

Policy Owner's Employer: _____

Orthodontic Coverage? ☐ Yes ☐ No

Why did you bring the child to the dentist today?

Has the child ever had any unhappy dental visits? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____

Date of last visit to physician: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No

Has the child been out of the country in the last 3 months? ☐ Yes ☐ No

Please describe the child's current health: ☐ Good ☐ Fair ☐ Poor

Please list all drugs that the child is currently taking: _____

Are your child's immunizations up to date? ☐ Yes ☐ No

Does your child have any drug allergies? ☐ Yes ☐ No

If yes, please list _____

Is your child allergic to latex? (Balloons, Bandaids, Bananas) ☐ Yes ☐ No

Please list any previous hospitalizations/surgeries/serious illnesses:

Does the child have any of the following habits?

Lip Sucking / Biting	☐ Yes	☐ No
Nail Biting	☐ Yes	☐ No
Grinds Teeth	☐ Yes	☐ No
Thumb / Finger Sucking	☐ Yes	☐ No

Has the child ever had any of the following medical problems?

Abnormal Bleeding/Hemophilia	☐ Yes	☐ No	Hearing Impairment	☐ Yes	☐ No
Allergies	☐ Yes	☐ No	Heart Disease	☐ Yes	☐ No
Anemia	☐ Yes	☐ No	Heart Murmur	☐ Yes	☐ No
Anaphylaxis	☐ Yes	☐ No	Heart Surgery	☐ Yes	☐ No
Any Hospital Stays/Operations	☐ Yes	☐ No	Hepatitis	☐ Yes	☐ No
Artificial Heart Valve/Joint	☐ Yes	☐ No	Herpes/Cold Sores	☐ Yes	☐ No
Arthritis	☐ Yes	☐ No	High Blood Pressure	☐ Yes	☐ No
Asthma	☐ Yes	☐ No	HIV/AIDS	☐ Yes	☐ No
Autism	☐ Yes	☐ No	Intellectual Disability	☐ Yes	☐ No
Blood Transfusion	☐ Yes	☐ No	Kidney/Liver Problems	☐ Yes	☐ No
Cancer	☐ Yes	☐ No	Leukemia	☐ Yes	☐ No
Cerebral Palsy	☐ Yes	☐ No	Measles	☐ Yes	☐ No
Chemotherapy/Radiation	☐ Yes	☐ No	Pacemaker	☐ Yes	☐ No
Chicken Pox	☐ Yes	☐ No	Pneumonia	☐ Yes	☐ No
Cleft lip/Palate	☐ Yes	☐ No	Pregnancy	☐ Yes	☐ No
Convulsions/Epilepsy/Seizures	☐ Yes	☐ No	Premature Birth	☐ Yes	☐ No
Cystic Fibrosis	☐ Yes	☐ No	Renal Dialysis	☐ Yes	☐ No
Diabetes	☐ Yes	☐ No	Rheumatic/Scarlet Fever	☐ Yes	☐ No
Diphtheria	☐ Yes	☐ No	Sickle Cell Disease	☐ Yes	☐ No
Down Syndrome	☐ Yes	☐ No	Speech Difficulties	☐ Yes	☐ No
Emotional, Mental, Nervous			Thyroid Disease	☐ Yes	☐ No
Disorder	☐ Yes	☐ No	Tuberculosis (TB)	☐ Yes	☐ No
Frequent Nose Bleeds	☐ Yes	☐ No	Vision Problems	☐ Yes	☐ No
Handicaps/Disabilities	☐ Yes	☐ No	Any Syndromes	☐ Yes	☐ No

If any of the above are checked, please give a brief explanation:

Authorizaton and Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is also my responsibility to inform this office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent of Guardian

The parent of guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

How did you hear about us?

We'd love to know how our patients hear about our office whether it's Facebook, Instagram, YouTube, Google reviews, our website, a referral of some sort, or something else! Please let us know how you heard about us! We look forward to providing you child's dental care!

KIDS DENTAL CENTER

Blain Reynolds, DDS

Consent for Dental Treatment

Since _____ is a minor, it becomes necessary that signed permission be obtained from the parent or guardian before any and/or all necessary dental services can be performed by Dr. Blain Reynolds, or, at times, a student dentist overseen by Dr. Reynolds. Authorization is hereby granted as such. I understand that should there be a procedure that I do not wish to be performed on my child that I must notify the office prior to my child's visit. In order to provide the best care for your child, a routine cleaning visit will include an exam, cleaning, fluoride and bitewing x-rays. Please note that no treatment will be done on your child without your prior consent.

Consent for Nitrous Oxide/Oxygen

(used on every patient during operative procedures)

Nitrous Oxide/oxygen is often used in the dental setting to help reduce anxiety. Risk of complications with nitrous oxide is rare, and its sedative effects are gone within five minutes after its use has been discontinued. The most common complications are nausea and vomiting.

I _____ as the legally responsible parent/guardian of _____ give my consent to the use of nitrous oxide/oxygen that Dr. Blain Reynolds and any other associates deem necessary or advisable so as to enable them to render necessary dental treatment as indicated on the child's examination chart, as previously explained to me, and any procedure deemed necessary or advisable as a corollary to the planned treatment.

I hereby state that I have read and understand this consent form, that I have been given an opportunity to ask questions I might have, and that all questions about the procedure or procedures have been answered in a satisfactory manner.

Parent's Name: _____

Signature of Parent/Guardian: _____ Date: _____

KIDS DENTAL CENTER

Blain Reynolds, DDS

FINANCIAL POLICY

_____ 1. **Payment is due at the time services are provided.** Our office accepts cash, checks, and major credit cards.

_____ 2. Our office will file most all insurances. Please note we are only a participating provider for Aetna Dental Extend, Ameritas, BCBS of TN, Cigna, Delta Dental PPO, Delta Dental Premier, Guardian, MetLife, Principal Life Insurance, UHC, UMR, TennCare and Cover Kids. **We recommend that you contact your insurance prior to your child's visit to verify coverage if you only wish to see a preferred provider.**

_____ 3. Our office does make an effort to obtain insurance benefit information; however, **we are not able to keep up with the specifics of each and every policy**. It is your responsibility to familiarize yourself with your personal policy; you may contact your insurance to find out specifics concerning coverage, insurance fee schedule, and frequency limitations. If your policy requires preauthorization or has benefits limitations, we need to be informed by you before treatment is rendered.

_____ 4. As a courtesy, we will file your primary insurance claim one time. You are ultimately responsible for the full amount charged for treatment; if insurance has not responded or paid claims within 90 days of service, it is your responsibility to clear the account. Insurances failure to pay does not release you from your responsiblity to pay.

_____ 5. All incurred charges are ultimately the responsibility of the patient, regardless of insurance coverage. We must emphasize that, as your dental care provider, our relationship is with you, our patient, and not with your insurance company. Your insurance plan is a contract between you, your employer and the insurance company. Our office is not a party to that contract or any possible restrictions.

_____ 6. Each 6 month cleaning visit will include an exam, cleaning, and fluoride so that we may provide consistent and quality dental care for your child. We will do bitewing xrays one time a year unless your child has a history of decay between the teeth. Children with braces may be on a 3 or 4 month schedule. In these cases your child will not receive an exam every visit - they will have an exam two times a year, a cleaning and fluoride every visit. Please contact your insurance if you have questions concerning yearly frequency limitations (ex. Some insurance companies only pay for fluoride once yearly).

_____ 7. If operative treatment is required, we will provide you with a treatment estimate. Our estimate of your co-pay, deductible and co-insurance is just that - an estimate. It is not a guarantee of coverage or payment from your insurance; you understand you will receive a bill for any remaining balance deemed your responsibility once insurance processes the claim.

_____ 8. Patient balances not resolved in a timely manner will be sent to an outside collection agency at the patient's expense. If your account is turned over for collection, your responsible for all collection agency fees, court costs, and all other costs of the collection.

_____ 9. We will not get involved with divorce decree arrangements. Both parents are responsible for a minor child's bill and both parents will be held accountable. Full payment is due from the person bringing the child at the time services are rendered.

_____ 10. A consent form must be signed and on file if anyone other than the legal guardian will be bringing the child to their appointments. Please contact our office for payment estimation and send payment with the person bringing your child for service.

_____ 11. If a refund is due to you after insurance has paid, please contact our office to request the refund. We will not issue a refund until all claims for the account have been paid. Refunds are issued by our accountant every other week, so please allow 2 to 3 weeks to receive a refund check.

_____ 12. A $35.00 charge will be incurred for missed appointments and appointments cancelled without twenty-four hour advance notice. Families with an unreasonable amount of failed appointments can result in a dismissal from the practice.

I, the undersigned, have read the above policies and understand they apply to <u>every</u> patient at Kids Dental Center. I have been given a copy of this Financial Policy.

Signature of Responsible Party

Date

KIDS DENTAL CENTER

Consent to bring child to appointment for treatment & Consent to Release Medical Information

I grant permission for the person(s) listed below (other than the parent/legal guardian) to bring my child to Kids Dental Center for dental treatment. I also grant permission for the person(s) listed below (other than the parent/legal guardian) to have access to any and all of my child's medical information that pertains to his/her care from the dentists of this group. This includes, but is not limited to, appointment times, his/her dentist's plans for dental care, etc. This consent can be revoked at any time by submitting a letter to Kids Dental Center in writing requesting to terminate this consent.

Please note: This permission is giving person(s) listed the authority to sign treatment plans presented on the day of appointment that approve treatment to be performed.

Name	Relationship to child
Name	Relationship to child
Name	Relationship to child
Name	Relationship to child
Name	Relationship to child
PARENT/LEGAL GUARDIAN SIGNATURE	DATE

KIDS DENTAL CENTER

Notice of Privacy Practices

You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our Notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures we make of your protected health information and other important matters about your protected health information. A copy of our notice is posted in the reception area and accompanies this consent. We reservce the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting our office at (423)458-4147.

READ CAREFULLY:

I have had the full opportunity to read and consider the contents of this consent form and the Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities, and healthcare operations.

Further, I am giving my consent to release records and or discuss and give consent for treatment, scheduling, and payments with the following individuals listed below.

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Name:_____ Relationship:_____

* I attest to the accuracy of the information on these pages.
* I grant permission for you and/or your assigners to telephone me at my house and/or work to discuss matters related to this form if necessary.
* I authorize the release of necessary information to the insurance company.
* I authorize direct payment to my provider, Kids Dental Center.

Signature indicates that I have read the above HIPAA Notice of Privacy Practices and agree to their content.

Signature of Patient/Parent or Guardian/Guarantor	Date	Relationship