

PATIENT INFORMATION

Child's Name: _____ Goes by: _____
 Child's Date of Birth: ___/___/___ Age _____ Sex: M or F SS#: _____-_____-_____
 Child's Home Address: _____
 City, State, Zip: _____
 Primary Contact Phone Number: (____)-____-____ School This Child Attends: _____ Grade: ____
 Please tell us about the patient's interests and hobbies:

Child Lives With: () Both Parents () Mother () Father () Splits time with _____ () Grandparent _____
 () Step-parent _____ () Foster Care () Other _____

PERSON FILLING OUT PAPERWORK

Name: _____ Relationship to patient: _____
 If other than parent, Legal Guardianship paperwork is required before any treatment can be rendered Are you permitted by law (by right as a natural parent, legal guardian, legal adoption, or court order) to provide consent for the dental treatment of this child? () Yes () No

 Signature

PARENT'S/GUARDIAN'S INFORMATION

___Mother ___Step Mother ___Guardian
 Name: _____ DOB: ___/___/___
 SSN: ___/___/___
 Address: _____
 City, State, & Zip: _____
 Home Phone: _____
 Cell Phone: _____
 Work Phone: _____
 Employer Name: _____
 Occupation: _____
 Job Title: _____
 Email: _____

___Father ___Step Father ___Guardian
 Name: _____ DOB: ___/___/___
 SSN: ___/___/___
 Parents live at same address
 Address: _____
 City, State, & Zip: _____
 Home Phone: _____
 Cell Phone: _____
 Work Phone: _____
 Employer Name: _____
 Occupation: _____
 Job Title: _____
 Email: _____

Do you have other children who are already established patients with our practice?
 If yes, name of patient(s): _____

PATIENT MEDICAL/DENTAL HISTORY

Primary Care Physician _____ Phone # _____ Date of last exam _____

Is this child taking Medicine now? No () Yes ()

List any Medications:

Treatment for:

Notes:

_____	_____
_____	_____
_____	_____

Has this child ever been hospitalized? No () Yes () WHY? _____

Has this child ever been treated in the emergency room? No () Yes () WHY? _____

Does this child have or has this child ever had any of the following conditions?

- | | |
|--|---|
| Yes () No () Allergies | Yes () No () Hypertension |
| Yes () No () Drug Reactions | Yes () No () Diabetes/Endocrine System |
| Yes () No () Latex Sensitivity | Yes () No () Cancer type: _____ |
| Yes () No () Asthma | Yes () No () Birth defects _____ |
| Yes () No () Breathing Problems | Yes () No () Cleft lip and/or palate |
| Yes () No () Premature/Low Birth Weight | Yes () No () Cerebral Palsy |
| Yes () No () Anemia | Yes () No () Delayed speech development |
| Yes () No () Bleeding Problem/Transfusion | Yes () No () Developmentally Delayed |
| Yes () No () Sickle Cell Anemia | Yes () No () Seizures type _____ |
| Yes () No () Heart condition/Murmur | Yes () No () Fainting spells |
| Yes () No () Rheumatic Fever | Yes () No () Hyperactivity/ADD/ADHD |
| Yes () No () TB, HIV, Hepatitis Type-_____ | Yes () No () Psychiatric/Emotional problems |
| Yes () No () Kidney Disease | Yes () No () Vision problems |
| Yes () No () Liver Disease | Yes () No () Hearing loss/impairment |
| Yes () No () Jaundice | Yes () No () Pregnancy |
| Yes () No () Frequent Headache | Yes () No () Frequent infections |

Other medical concerns: _____

What brings you in today? (What is your main dental concern?) _____

Has your child previously seen a dentist? () No () Yes: what dental practice, name of dentist? _____

How often does the patient brush? _____ Floss? _____ By Whom? _____

Does this patient have a special diet? () No () Yes _____

What does child drink on an average day? () Cows milk () Juice () Breastmilk () Water () Gatorade () Soda () Energy drinks () Coffee () Favorite drink _____

I certify that I have read and understand the above information is to the best of my knowledge. the above questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to the health of this patient. I will not hold Dr. Rachel Witcher or any staff responsible for any errors in omissions that I may have made during the completion of this form.

Signature x _____ Date: _____

REFERRAL INFORMATION

How did you hear about our office? (Check all that apply.)

- | | |
|--|-----------------------------|
| () Family/Friend: _____ | () Facebook |
| () Dr's Office: _____ | () Google |
| () Magazine | () Insurance company |
| () First pediatric dentist that popped up on Google | () Promotional offer _____ |
| () Most established office that popped up on Google | () Other _____ |

DENTAL INSURANCE INFORMATION

- No, I don't have dental insurance
 Yes, I have dental insurance (please give card to front desk to scan or email electronic copy to info@thekidsdentalplace.com)
- Insurance Company: _____ Policy Number: _____ Address To Mail Claims: _____
Name of Policy Holder: _____ Group number: _____
Date of Birth: ___/___/___ SS# ___/___/___ Insurance Phone Number: _____
- I have provided my insurance card to front desk to be scanned
 I do not have my card with me to provide to front desk but will email to info@thekidsdentalplace.com when I get home

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I, _____ acknowledges receipt of a copy of the current effective Notice of Privacy Practices policy. A copy of this signed, dated acknowledgment shall be effective as the original.

Signature

OFFICE POLICY FORM/CONSENT PRACTICES

Please read and initial next to each paragraph.

___ I understand that an initial and recall dental appointment can include a visual exam of the oral area, a radiographic (x-ray) exam, prophylaxis (cleaning), Fluoride treatment, and Oral Hygiene Instruction (OHI) when necessary. I understand that digital photographs will be taken as part of my child's clinical record. I give permission to Dr. Rachel Witcher and her team to perform these examinations and procedures on my child at the initial and each subsequent recall appointment. I understand that these services are Dr. Rachel Witcher's standard of care based on the American Academy of Pediatric Dentistry guidelines, and are not based on insurance benefits or coverage frequency.

___ Please be advised that scheduling an appointment is your confirmation of the appointment. Not being contacted by the office is not an excusable reason for any missed appointments. As a courtesy to others who would like to be scheduled, there is \$25.00 no show/cancellation fee for missed or cancelled appointment without 24 hours notice.

___ We are a specialty clinic and all fees are due at the time of service. Some services require to be prepaid in order to reserve an appointment time. As a courtesy, we will provide an insurance claim form to be mailed by the patient/guarantor.

___ Be sure to arrive at your appointment on time. We respect our patients' time and make every effort to remain on schedule. If more than 10 minutes late to scheduled appointment, visit may need to be rescheduled. Dr. Rachel Witcher will not "rush" to "make up" the time lost.

___ Electronic Communication Consent: I agree that this practice may electronically communicate with me through the email address and phone numbers I have provided.

PATIENT AUTHORIZATION FORM

I consent to the following people, whether legal guardian or not, to bring my child in for their dental appointment and give these people the ability to make dental/medical treatment decisions for my child:

1. I give authorization to release medical Information to Family Member(s), Guardian, and others.
2. I give authorization for consent for Family Member(s), Guardian, and others to accompany patients to dental/medical appointments.
3. I give authorization for Family Member(s), Guardian, and others to consent to dental/medical treatment.

Name: _____	Relation to Patient: _____
Name: _____	Relation to Patient: _____
Name: _____	Relation to Patient: _____
Name: _____	Relation to Patient: _____

When will caregiver's authorization begin? Date: _____

Do you want to set an end date? Yes or No (please circle one)

If yes, Date: _____

Patient Name (Please Print)

Legal Guardian name (Print)

Legal Guardian Signature

Date

CONSENT FOR TREATMENT

(Please include all patient names' below, including siblings to consent for treatment at our practice.)

Patient Name(s): _____

I, being the parent or guardian of the above minor patient(s), hereby do authorize and request the performance of dental services for the patient(s) and the use of whatever procedures the doctor may deem necessary during treatment.

I understand that Dr. Bonnin, Dr. Rachel, and Dr. Witcher, as well as, assistants as he may designate to treat the above-mentioned patient(s) will use restorative, oral surgery, orthodontic, and patient management techniques that are reasonable, necessary and advisable.

I also authorize the administration of anesthetics or analgesics, which may be deemed advisable by Dr. Bonnin, Dr. Rachel, or Dr. Witcher.

I understand that the treatment plan to be presented, along with the fees outlined, could change depending upon the time elapsed since the initial examination and the extent of dental pathology. Furthermore, by signing this, I agree to be responsible for full payment of all charges for dental services performed on the above-named patient or patients.

I hereby authorize and consent to any treatment or procedure or the administration of necessary anesthetics which my child's dentist deems advisable in the diagnosis and/or treatment of this patient. By signing this medical authorization and consent, I understand that as a matter of law it shall be conclusively presumed:

- A) That the action of my dentist in obtaining this consent from me was in accordance with an accepted standard of medical-dental practice among members of the medical-dental profession with similar training and experience in this or similar medical communities; and from information provided me by my dentist, I under these circumstances, have at least a general understanding of the procedures, the medically accepted alternate procedures or treatments and the substantial risks and hazards inherent in the proposed treatment or procedures which are recognized among dentists in this of a similar community who perform similar treatments or procedures; or

- B) That I, considering all the surrounding circumstances, would have undergone such treatment or procedure had I been advised by my dentist as described in paragraph A above.

Signature of Authorized person on behalf of patient Date

CONSENT FOR DENTAL PHOTOGRAPHY AND SOCIAL MEDIA FORM

PATIENT CONSENT

I, _____
First name *Last name*

consent to dental images and / or video being made of me or my child / dependent.
 I agree that duplicates may be made for the referring doctor.

I agree that the images may be:
(Please check below to show consent)

	Yes	No
... placed in my dental record for future treatment	_____	_____
... electronically emailed to my treating health professional	_____	_____
... used by dental health professionals for education and training	_____	_____
... used in paper or electronic dental health publications	_____	_____
... used in commercial broadcast	_____	_____
... used in marketing materials (Facebook/Website)	_____	_____

By signing below, I confirm that I understand this consent form.

 Signature of Authorized person on behalf of patient Date