New Patient Information

Date: ________________________

Tell us about your child/children

First Name: ____________________ First Name: ____________________ First Name: ____________________
Last Name: ____________________ Last Name: ____________________ Last Name: ____________________
Birthdate: ____________________ Birthdate: ____________________ Birthdate: ____________________
Age: _____ ☐ Male ☐ Female Age: _____ ☐ Male ☐ Female Age: _____ ☐ Male ☐ Female

First Name: ____________________ First Name: ____________________ First Name: ____________________
Last Name: ____________________ Last Name: ____________________ Last Name: ____________________
Birthdate: ____________________ Birthdate: ____________________ Birthdate: ____________________
Age: _____ ☐ Male ☐ Female Age: _____ ☐ Male ☐ Female Age: _____ ☐ Male ☐ Female

Child/Children lives with: ☐ Father ☐ Mother ☐ Both ☐ Other____________________________

Address: ____
Street City State Zip

Whom may we thank for referring you? ☐ Website ☐ Facebook ☐ Drive by ☐ Google
☐ Family/Friends (name) ________________________ ☐ Referring Dentist (name) ____________________

Mother's Information
☐ Mother ☐ Stepmother ☐ Legal Guardian
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed

Name: ____________________________________
Birthdate: ____________________________________
Social Security Number: ____________________________
Address (if different than child's) ____________________
____
Home Phone: ____________________________________
Cell Phone: ____________________________________
Work Phone: ____________________________________
E-mail Address: ________________________________
Employer: ____________________________________
Do you have dental insurance for minor/child/children? Yes/No
Plan Name: ________________ PH #: ______________
Address: ____________________________________
Policy # ____________________________________

Father's Information
☐ Father ☐ Stepfather ☐ Legal Guardian
☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widower

Name: ____________________________________
Birthdate: ____________________________________
Social Security Number: ____________________________
Address (if different than child's) ____________________
____
Home Phone: ____________________________________
Cell Phone: ____________________________________
Work Phone: ____________________________________
E-mail Address: ________________________________
Employer: ____________________________________
Do you have dental insurance for minor/child/children? Yes/No
Plan Name: ________________ PH #: ______________
Address: ____________________________________
Policy # ____________________________________

Emergency Contact: Phone: Relation:

Consent Treat

I am the parent/legal guardian of____
and I have the legal authority to give consent for dental treatment for him/her/them.

- I give consent to Kaysville Pediatric Dental as they may designate to provide treatment for my child/children named above.
- I give consent to the use of local anesthetics, nitrous oxide (laughing gas), and other medicines or materials **IF WHEN AND IF REQURED**. I give consent to other procedures, including, but not limited to emergency medical procedures, which may be deemed necessary or advisable.
- I understand that, although good results are expected, the possibility and nature of complications cannot always be accurately anticipated in advance and therefore, there is no guarantee expressed or implied as to the result of the treatment or as to cure.
- I have these questions or concerns: ____

Financial Agreement

I understand payment is due in full for each appointment as services are rendered. If I have dental insurance, I understand KPDO will collect my **ESTIMATED** portion. As a courtesy, KPDO will file my insurance claims. Any amount determined not to be covered by my insurance is due at the time services are rendered. These fees may include deductibles, co-payments, and procedures not covered by my insurance policies**. IT IS MY RESPONSIBILITY TO KNOW AND UNDERSTAND MY INDIVIDUAL BENEFITS AS EVERY PLAN IS DIFFERENT**. We accept cash, personal checks, Visa, Mastercard, Discover, AMEX, AND Care Credit. **There will be a $25 returned check fee** assessed to your account if returned for any reason. **Dental Insurance:** KPDO is dedicated to providing all of our patients with the finest treatment available and base our treatment recommendations on what will be best for your child and not what your insurance company does or does not pay.

24 Hour Cancellation/Missed Appointment Policy I am Fully aware that a **$25 charge or up to $50 per family** will be applied to my account for all **missed appointments** as well as appointments canceled without a **24-hour notice**.

Past Due Accounts: If my account becomes past due, I understand KPDO will take the necessary steps to collect this debt. Service fees of 1.5% per month (18% per annum) will be added on all accounts over 60 days. Should collection become necessary against me, I agree to pay additional 40% collection fee, and all legal fees of collection, with or without suit, including attorney's fees and court costs.

____
Signature of Parent/Guardian Date

____
Please Print Name of Parent or Guardian Relationship to Patient/Patients

Notice of Privacy Practices HIPAA

I have been given the right to review and receive a copy of Kaysville Pediatric Dental and Orthodontics' Notice of Privacy Practices. I understand that this organization has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

____
Patients Names Relationship to patients

____
Print Name Signature Date

Kaysville Pediatric Dental and Orthodontics

Dental History

Patient's name____ Birthdate____________________
(First) (Last)

Male or **Female** (please circle one) Nickname____

Siblings seen at our office ____

Reason for this appointment? ☐ Checkup ☐ Toothache ☐ Orthodontics ☐ Other____________________

Is this patient's first visit to the dentist? **Yes No** Date of Last visit ____________________

Previous Dentist's name____________________ Reason for last visit____________________

How can we help make this a positive visit for your child? ____

Was your child bottle fed? **Yes No** until what age? __________ Breast Fed? **Yes No** Until what age? ____________

Does your child go to nap/bed with a bottle or sippy cup? **Yes No**

Does your child have any of the following oral habits?

☐ Pacifier ☐ Thumb Sucking/Finger Sucking ☐ Nail Biting ☐ Other: ____________________

Does your child eat food or drink beverages (including juices, milk and soda) five or more times in a day? **Yes No**

Has your child ever had any injuries to teeth/mouth/head? Broken or chipped teeth? **Yes No**

If Yes please explain: ____

Does your child:

Brush his/her teeth daily? **Yes No** Floss teeth daily**? Yes No** With parent help? **Yes No**

Medical History

Child's pediatrician: ____________________ Phone # ____________________

Date of last physical exam: ________________

Is your child under the care of physician now for a **specific medical condition** currently? **Yes No**
If yes, please explain: ____

Has your Child been seen by a **cardiologist**? **Yes No**

Is/has your child:

	Yes	**No**	if yes:
Immunizations up to date?	☐	☐	
Currently taking any medications?	☐	☐	List____
Ever Been Hospitalized?	☐	☐	Date/Why ____

____

Ever Had surgery?	☐	☐	Date/Why ____

____

	Yes	No	
Allergic to any medications?	☐	☐	List/reaction ________________________
Allergic to Latex?	☐	☐	List/reaction ________________________
Allergic to nuts?	☐	☐	Kind/reaction ________________________
Seasonal Allergies?	☐	☐	Reaction ________________________
Any other diagnosed allergies? (environmental,metals, foods, dyes, etc.)	☐	☐	List/reaction ________________________

Please circle one: **Y** for yes, patient has current conditions, **N** no conditions, or **H** for a previous history of any conditions your child may have had:

General

Y N H Acid Reflux
Y N H A.D.D/A.D.H.D
Y N H Autism
Y N H Anxiety (Diagnosed)
Y N H Cancer
Y N H Cleft Lip/Palate
Y N H Cranial Facial Disorder
Y N H Depression
Y N H Development Delays
Y N H Earaches
Y N H Fainting
Y N H Gag Reflex
Y N H Hearing Impaired
Y N Pregnant
Y N H Premature birth___weeks
Y N H Sinus Problems
Y N H Stomach Disorders
Y N H Speech Impaired or Delayed

Blood/Urinary

Y N H Anemia
Y N H Bleeding Disorder
Y N H Hepatitis
Y N H Kidney Problems
Y N H Diabetes

Heart

Y N H Heart Murmur
Y N H Heart Problems
Y N H Heart Pre-med
Y N H Rheumatic Fever

Neurological

Y N H Cerebral Palsy
Y N H Epilepsy/Seizures
Y N H Learning Delay
Y N H Mental Delays
Y N H Physical Delays
Y N H Physical Handicap

Respiratory

Y N H Asthma
Y N H Respiratory Conditions
Y N H Sleep apnea
Y N H Snoring
Y N H Tuberculosis

If you answered Y or H to any questions, please detail the conditions below: ______________________________

____

____

Special needs/addition medical conditions/Other:______________________________________

____

The above medical, dental and medication history is complete and accurate to the best of my knowledge. I will notify you if **ANY** changes to the patient's health history prior to **ANY** appointments.

Signed (Parent/Guardian): ______________________________ Date: ________________

Dentist Signed: ______________________________ Date: ________________