MyKidz DENTIST

Welcome!

Our mission is to ensure that each child and family receive respect, support and the finest dental care and orthodontic treatment in a safe and nurturing environment. Our goal is that each visit to our dental home is an educational and positive experience.

1 Tell us about your child

Today's Date _____

Patient's Name _____
Last First

Patient's Birthdate _____ Age _____

Nickname _____ ☐ Male ☐ Female

Home Address: _____

_____
City State Zip

Whom does the child live with? _____
Relationship to child _____
Child's Home # _____
Previous Dentist _____
Pediatrician _____
Pediatrician Phone _____

2 Parent's Information

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

Mother ☐ **Step Mother** ☐ **Guardian**
Name _____
Birthdate _____
Cell _____
☐ Same as Above
Address: _____

_____
City State Zip
SSN# _____ DL# _____

Father ☐ **Step Father** ☐ **Guardian**
Name _____
Birthdate _____
Cell _____
☐ Same as Above
Address: _____

_____
City State Zip
SSN# _____ DL# _____

3 Who is accompanying the child today?

Name _____
Relationship _____
Do you have legal custody of this child? ☐ Yes ☐ No
Whom may we thank for referring you?
_____

4 Person responsible for account – This is Person signing this form and bringing child in. (Even if NOT the Insured Party).

Name _____
Relationship _____
Billing Address _____

_____
City State Zip

5 Primary Dental Insurance

Dental Coverage? ☐ Yes ☐ No
Dual Insurance? ☐ Yes ☐ No.(If Divorced, please list the **Primary Insured** in accordance with the Divorce Decree)
Member Name _____
Member ID _____ Group # _____
Member's Birthdate _____ SSN: _____
Member's Employer _____
Relationship to Patient _____
Insurance Name _____
Insurance Address _____

_____
Insurance Phone # _____

Secondary Dental Insurance

Dental Coverage? ☐ Yes ☐ No
Member Name _____
Member ID _____ Group # _____
Member's Birthdate _____ SSN: _____
Member's Employer _____
Relationship to Patient _____
Insurance Name _____
Insurance Address _____

_____
Insurance Phone # _____

6 Patients' Dental History

Reason for today's visit _____

Is this your child's first visit to the dentist? ☐ Yes ☐ No If No, date of last dental examination _____

Is this an emergency visit? ☐ Yes ☐ No

If your child is having dental problems, please explain: _____

_____

Was your child ☐ Breast Fed ☐ Bottle Fed At what age did it stop? _____

How often does your child brush daily? ☐ Once ☐ Twice ☐ Seldom ☐ By Parent ☐ By Child ☐ Both

How often does your child floss? ☐ Once ☐ Twice ☐ Seldom ☐ By Parent ☐ By Child ☐ Both

How do you think your child will react to this dental visit? ☐ Cooperative ☐ Uncooperative ☐ No Sure

7 Patients' Medical History

Is your child under the care of a physician? ☐ Yes ☐ No If Yes, Why? _____

Has your child been hospitalized? ☐ Yes ☐ No If Yes, when and why? _____

Allergies _____

Allergies to medications _____

Is your child currently taking any medications? ☐ Yes ☐ No If Yes, please list: _____

DOES YOUR CHILD HAVE OR HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING CONDITIONS?

Y / N Anemia
Y / N Asthma
Y / N Autism
Y / N Birth Defects
Y / N Bleeding Problems
Y / N Blood Disorders
Y / N Blood Transfusions
Y / N Cancer
Y / N Cerebral Palsy
Y / N Cleft Lip/Palate
Y / N Chronic Ear Infection
Y / N Cystic Fibrosis
Y / N Delayed Speech
Y / N Development Delay
Y / N Diabetes
Y / N Down Syndrome
Y / N Emotional Problems
Y / N Epilepsy
Y / N G-Tube Feeding
Y / N Hearing Impairment
Y / N Heart Condition
Y / N Heart Murmur
Y / N Hepatitis
Y / N Herpes
Y / N High Blood Pressure
Y / N HIV / AIDS
Y / N Hyperactivity / ADHD
Y / N Kidney Disease
Y / N Learning Disabilities
Y / N Liver Disease
Y / N Muscular Dystrophy
Y / N Pregnant
Y / N Psychiatric Problems
Y / N Radiation Therapy
Y / N Rheumatic Fever
Y / N Seizures
Y / N Sexually Transmitted Diseases
Y / N Sickle Cell Anemia
Y / N Skin Disorders
Y / N Sleep Apnea
Y / N Snoring
Y / N Spinal Bifida
Y / N Tuberculosis
Y / N Tumors
Y / N Syndrome (specify)_____

PLEASE LIST ANY ADDITIONAL MEDICAL CONCERNS: _____

To the best of my knowledge the indicated health history remains current and any changes in the patients' health or medications will be updated. I will not hold my Doctor or Staff responsible for any errors or omissions that I have made in completion of this form. I understand that withholding this information may affect the outcome of the procedures or course(s) of treatment. I give consent for the doctors of MKD to complete a thorough exam on the patient previously named, including any needed radiographs.

_____ _____
Signature of Parent / Guardian Date

_____ _____
Reviewed by Doctor Date

MY KIDZ DENTIST

"Dentistry and Orthodontics for Children and Teenagers"

1515 E. Bethany Home Road
Suite 140
Phoenix, AZ 85014
(602) 995-7336
Fax: (602) 995-2665

9305 W. Thomas Rd.
Suite 580
Phoenix, AZ 85037
(623) 474-2470
Fax: (623) 474-2477

19636 N. 27th Ave.
Suite 403
Phoenix, AZ 85027
(623) 879-8866
Fax: (623) 298-0386

CONSENT FORM

The following person(s), including step-parents, grandparents, family members, or friends of at least 18 years of age, have my permission to bring and give consent for **treatment changes for:**

Patient's Name: _____ D.O.B. ____/____/____

to My Kidz Dentist, for dental care and treatment(s). The person(s) listed below can also receive dental advice; will be able to pick up necessary prescriptions other than controlled substances, x-rays; Inquire and receive financial information concerning the above patient in person or over the phone.

Name: _____

Address: _____
City: _____
State: _____ Zip Code: _____
Relationship: _____
Phone: (_____) _____ - _____

Name: _____

Address: _____
City: _____
State:_____ Zip Code: _____
Relationship: _____
Phone: (_____) _____ - _____

_____

(Signature of Parent or Legal Guardian)

Date: _____/ _____ /_____

MY KIDZ DENTIST

OFFICE/FINANCIAL POLICY

We are dedicated to providing the best possible care and service to you and your child (ren). Your complete understanding of our office and financial policies are an essential element of your child(rens) care and treatment. If you have any questions, please discuss them with our front office staff prior to treatment.

As a courtesy, we will be happy to file your primary insurance benefits, though we are not obligated to do so. Your dental insurance plan is a contract between you, your employer and the insurance company. Our office does not determine your dental benefits. Many carriers will not reimburse our office because we are a specialist. In this instance, you will be responsible for the costs of each visit at the time services are provided and your insurance company will send you the reimbursement check directly. **Any amount not covered by insurance is payable at the time services are rendered.** These fees may include deductibles, co-payments or certain procedures not covered by your insurance policy. Unfortunately, some of the services that we may recommend for your child will not be covered by your specific dental insurance. We will allow a maximum of 30 days for your insurance company to clear account balances. If your insurance has denied your claim due to the lack of information, we will look to you for payment and encourage you to call your insurance company to make sure they have the proper information. **Any unpaid portions will be due in full by you, after this period.**

FINANCIAL POLICY:

Change in Insurance Plan: You are expected to notify our office if your insurance coverage has changed. Our office will periodically ask you to update your records. We are to be provided with full and complete information in order for our office to bill the correct insurance company for you.

Financing Programs: To help provide cost effective care to our patients, we offer the **Care Credit** financing program for both dental and orthodontic treatment. We do not offer payment plans.

Financial Obligation: After attempts to collect outstanding funds and a 90 day grace period from the time of service, parents/guardians not fulfilling their financial obligation will be sent to collections as stipulated by our accountants. You will be responsible for any legal fees. In addition to your balance, 35% of the balance due will be assessed as a collection fee/cost.

Method of Payments: For your convenience we accept cash, debit/credit cards (Visa, MasterCard, American Express and Discover Card).

Non-Insured Patients: We offer a 10% cash discount for patients with NO INSURANCE. Payment method is CASH ONLY and applies to balances of $100.00 or more. We don't offer this discount to patients who are enrolled in any type of dental discount plan.

OFFICE POLICY:

One Parent Policy: We allow one parent/guardian back in the treatment rooms, no other siblings or children will be allowed. If you have other children, please make prior child care arrangements. If you need to bring other children to an appointment you will be asked to wait in the waiting room with them.

Responsible Party: The parent or guardian who accompanies the child is responsible for payment at times of service unless prior arrangements have been made. If you share financial responsibility it is up to the responsible party to pay on the account and seek reimbursement.

Missed Appointments: Our office requires a 24-hour notification if you need to cancel or reschedule an appointment. Failure to contact our office in advance will result in a $25.00 fee billed to your account.

HIPPA

I understand that I may inspect or copy the protected health information described by this authorization. I understand that at any time, this authorization may be revoked, when the office that receives this authorization receives a written revocation, although that revocation will not be effective as to the disclosure of records whose release I have previously authorized where other action has been taken in reliance on an authorization I have signed. I understand that my healthcare and the payment for my healthcare will not be affected if I refuse to sign this form. I understand that information used or disclosed, pursuant to this authorization, could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I hereby acknowledge that a copy of this office's Notice of Privacy Practices has been made available to me. I have been given the opportunity to ask questions I may have regarding this Notice.

I acknowledge receipt of the office and financial policies. I understand that this office cannot make an exact estimate of insurance benefits since it does not have access to all insurance company records. I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice. I assume all financial responsibility even though I may have dental benefits. **I HEREBY AUTHORIZE PAYMENT OF INSURANCE BENEFITS DIRECTLY TO MY KIDZ DENTIST.**

Child's Name: _____ Date of Birth: _____

_____ _____

Signature of Parent/Guardian Print Name of Parent/Guardian Date