

Welcome Kids

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!

Tell Us About Your Child

Today's Date: _____

Child's Name: _____

Last

First

MI

Child's Birthdate: ____/____/____ Child's Age: _____

Nickname: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Hobbies: _____

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

Child's Home Address: _____

Apt / Condo #

City

State

Zip

General Information

Who is accompanying the child today?

Name: _____ Relation: _____

☐ Yes ☐ No

Do you have legal custody of this child?

Whom may we Thank for referring you? _____

Other siblings: _____

Previous / Present Dentist: _____ Last Visit Date _____

Dentist's Phone #: (____) _____

Relative or Friend not living with you:

Name: _____ Phone: (____) _____

Address: _____

City

State

Zip

Parent's Information

Who is responsible for account? _____

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

☐ Father ☐ Mother ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's) _____ Hm #: (____) _____

SS #: _____ DL #: _____

Wk #: (____) _____ Ext: _____ Cell/Other #: (____) _____

Email: _____

Employer: _____

Employer's Address: _____

City

State

Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

City

State

Zip

Insurance Phone: (____) _____

Group # (Plan, Local, or Policy #): _____

☐ Mother ☐ Father ☐ Step Parent ☐ Guardian

Name: _____ Birthdate: ____/____/____

Address: (If different than Child's) _____ Hm #: (____) _____

SS #: _____ DL #: _____

Wk #: (____) _____ Ext: _____ Cell/Other #: (____) _____

Email: _____

Employer: _____

Employer's Address: _____

City

State

Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

City

State

Zip

Insurance Phone: (____) _____

Group # (Plan, Local, or Policy #): _____

Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

Signature of Parent or Guardian

Date

Dental History

Why did you bring the child to the dentist today? _____

Has your child ever been prescribed Fosamax or any other bisphosphonate? If yes, when? ☐ Yes ☐ No

Is the child currently in pain? ☐ Yes ☐ No

Does the child require antibiotics before dental treatment? ☐ Yes ☐ No

Has the child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

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

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

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

Floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

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

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

Please list all prescription / over the counter or herbal supplement drugs that the child is currently taking: _____

Aside from the items below, please list all drugs/things that the child is allergic to: _____

☐ Yes ☐ No Latex ☐ Yes ☐ No Metals/Nickel ☐ Yes ☐ No Plastic

Medical History

Has the child experienced the following medical problems?

☐ Y ☐ N Abnormal Bleeding / Hemophilia	☐ Y ☐ N Hearing Impairment
☐ Y ☐ N ADD/ADHD	☐ Y ☐ N Heart Murmur
☐ Y ☐ N AIDS/HIV+	☐ Y ☐ N Hepatitis
☐ Y ☐ N Anemia	☐ Y ☐ N High Blood Pressure
☐ Y ☐ N Any Hospital Stays/Operations?	☐ Y ☐ N Hives
☐ Y ☐ N Artificial Bones/Joints/Valves	☐ Y ☐ N Kidney Problems
☐ Y ☐ N Asperger Syndrome	☐ Y ☐ N Liver Problems
☐ Y ☐ N Asthma	☐ Y ☐ N Low Blood Pressure
☐ Y ☐ N Autism	☐ Y ☐ N Lupus
☐ Y ☐ N Cancer	☐ Y ☐ N Measles
☐ Y ☐ N Chicken Pox	☐ Y ☐ N Mitral Valve Prolapse
☐ Y ☐ N Congenital Heart Defect	☐ Y ☐ N Mononucleosis
☐ Y ☐ N Convulsions	☐ Y ☐ N Prosthetics
☐ Y ☐ N Diabetes	☐ Y ☐ N Rheumatic Fever
☐ Y ☐ N Epilepsy	☐ Y ☐ N Scarlet Fever
☐ Y ☐ N Exposed to HIV, but Neg.	☐ Y ☐ N Skin Rash
☐ Y ☐ N Handicaps/Disabilities	☐ Y ☐ N Tuberculosis (TB)

Are the child's immunizations current? ☐ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Please discuss any serious medical problems the child experiences/ed: _____

Does/did the child experience any of the following?

☐ Y ☐ N Breast Fed	☐ Y ☐ N Nursing Bottle Habits
☐ Y ☐ N Chewing on Objects	☐ Y ☐ N Speech Problems
☐ Y ☐ N Clenching/Grinding Teeth	☐ Y ☐ N Thumb/Finger Sucking
☐ Y ☐ N Lip Sucking/Biting	☐ Y ☐ N Tongue/Cheek Biting
☐ Y ☐ N Mouth Breather	☐ Y ☐ N Tongue Thrust
☐ Y ☐ N Nail Biting	☐ Y ☐ N Used Pacifier

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of Parent or Guardian

Date

OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY OFFICE USE ONLY

I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein. _____

Signature of Dentist

Date

Dentist's Comments: _____

Medical History Update

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N
If Yes, please explain. _____

Parent/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N
If Yes, please explain. _____

Parent/Guardian Signature _____ Date _____

Dentist Signature _____ Date _____



INSURANCE

Primary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID # _____

Insured's Employer: _____

Employer's Address: _____

Secondary Insurance

Dental Coverage? ☐ Yes ☐ No

Insurance Co. Name: _____

Insurance Co. Address: _____

Insurance Co. Phone#: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____ Relation: _____

Insured's Birthdate: ____/____/____ Insured's ID # _____

Insured's Employer: _____

Employer's Address: _____

Whom may we Thank for referring you? _____



FINANCIAL POLICY

Thank you for choosing our office for your superior dental care. We are committed to providing you with the best possible care. We are pleased to discuss our service with you at any time. Your clear understanding of our financial and liability policies is important to our professional relationship. By signing below, you are in agreement with our policies.

Insurance

Insurance is a contract between you and your insurance company. We file claims on your behalf as a courtesy to our patients. We will not become involved in any disputes between you and your insurance company regarding deductibles, co-payments, covered charges, "usual & customary" charges, other than to supply factual information as necessary. You are responsible for a timely payment of your account. Not all necessary services are covered benefits in all contracts. The majority of carriers have a dental maximum that they will pay in any benefit year. Any fees not covered by your insurance company are due at the time of treatment. A dental benefit estimate will be made when services are provided.

Self Pay

If you do not have dental insurance, payment is expected in full at the time of your visit. If a payment plan is necessary, arrangements must be made prior to beginning any treatment. Any balances that extend over 90 days are subject to a monthly finance charge. We accept Cash and Checks, Visa, Mastercard, and Discover.

Cancellation Policy

A minimum of 24 hours notice is required for all cancellations. A charge will be made in the second violation of this policy.

Professional Liability

I understand that dentistry is not an exact science and therefore, reputable practitioners cannot fully guarantee results. I acknowledge that no guarantee or assurance has been made by anyone regarding dental treatment, which I have requested or had been recommended to me. I understand that I have the opportunity to ask any questions prior to any dental treatment.

I have read the above policies and fully understand this agreement.

Patient's Name

Date



No Show, or Missed Appointment Office Policy

When our staff books your appointment, we are setting aside a dedicated time slot just for you. Your materials are ordered, and we make special arrangements to be ready for your visit. Except for emergency treatment for another patient, you can expect us to be prompt.

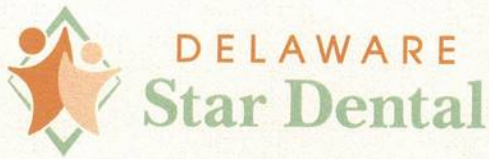
We ask that if you must reschedule your appointment, that you please provide us with at least 24 hours notice. This courtesy makes it possible to give your reserved time slot to another patient who would be more than happy to accept.

Delaware Star Dental will charge \$75.00 for not providing us with at least 24 hours notice to cancel an appointment, or any missed scheduled appointments.

Repeated cancellations or missed appointments will result in loss of future appointment privileges.

Name

Date



PATIENT AUTHORIZATION FORM

Authorization to Release Information to Family Members

Many of our patients allow family members such as their spouse, significant other, parents or children to call and request the result of test, procedures and financial information. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental information, any diagnostic test results and/or financial information released to any family members you must sign this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Delaware Star Dental to release my records and any information requested to the following individuals.

1. _____ Relation to Patient: _____
2. _____ Relation to Patient: _____
3. _____ Relation to Patient: _____
4. _____ Relation to Patient: _____

Authorization Regarding Messages (please check all that apply)

____ I authorize you to leave a detailed message on my home or cell number regarding appointments.

____ I authorize you to leave a message with anyone who answers the phone

Patient Name (PLEASE PRINT)

Date

Patient Signature



PHOTOGRAPH RELEASE FORM

I, _____ give Delaware Star Dental the right to use photographs of me. I authorize Delaware Star Dental to use and publish images in print and/or electronically. I agree that Delaware Star Dental may use such photographs of me with _____ or without _____ my name and for any marketing purpose, including but not limited to publicity, illustration, advertising, brochures, office displays, and web content, etc.

I have read and understand the above:

Signature: _____

Print Name: _____

Date: _____

Witness: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY/SECURITY PRACTICES DELAWARE STAR DENTAL

**** You May Refuse to Sign This Acknowledgement ****

I, _____, have reviewed and understand this office Notice of privacy Practices. I agree with the policies and procedures outlined and have been given an opportunity to select alternative methods of communication/ payment and/or restricting communication.

(Please Print Name)

(Signature)

(Date)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, acknowledgement could not be obtained because:

- _____ **Individual refused to sign**
- _____ **Communications barriers prohibited obtaining the acknowledgement**
- _____ **An emergency situation prevented us from obtaining acknowledgement**
- _____ **Other (Please Specify)**

2002 American Dental Association
All Rights Reserved

Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution form by any other party requires the prior written approval of the American Dental Association.

This form is education only, does not constitute legal advice, and covers only federal, not state, law.