KidsFirst Dental

Child's Name (First and Last): ____Nickname: ____________________
Male / Female   Age______________   Date of Birth_____________   Child lives with: Mother ___ Father ___ Both ___

Father's Name ______________________ Employer_________________ Social Security #_________________ DOB ________
Mother's Name______________________ Employer_________________ Social Security #_________________ DOB ________
Address ____City/State ___________________ Zip_____________
Home Phone #_______________ Mother's Cell #_______________ Father's Cell #_______________ Other # _____________
Email Address for confirmations: ____
How did you hear about us? ☐School Screening ☐Friend/Family ☐Mailer/Flyer ☐Doctor: ____________ ☐Other: __________

Date and place of last dental care: ____
Are your child's immunizations complete   Yes ___   No ___   On Schedule ___   Lacking What? ______________________________
Has your child had any of the following?

☐	Asthma	☐	Lung Problems	☐	Jaundice	☐	Diabetes
☐	Blood Problems	☐	Liver Problems	☐	Hepatitis	☐	Epilepsy
☐	Blood Pressure Problems	☐	Kidney Problems	☐	Fainting Spells	☐	Hay Fever
☐	Rheumatic Fever	☐	Mumps	☐	Arthritis	☐	Special School Needs
☐	Heart Problems	☐	Measles	☐	Tuberculosis	☐	Other: __________

Has your child ever been given: ☐ Local Anesthetic ☐ General Anesthesia ☐ Antibiotics: ______________________

Does/Did the child have….	**Yes**	**No**	**Please Describe:**
Any adverse reactions to the above?	☐	☐	______________________________
Any family history of problems with the above?	☐	☐	______________________________
Any medication taken daily?	☐	☐	______________________________
Any known allergies?	☐	☐	______________________________
Prolonged bleeding or frequent nosebleeds?	☐	☐	______________________________

Your child's social and dental history:	Yes	No
Do you consider your child to be high strung or generally nervous?	☐	☐
Is your child having any difficulty in school?	☐	☐
Does your child have a history of physical or emotional abuse?	☐	☐
Has your child had any unfavorable experience in a dental or medical office?	☐	☐
Does your child have any oral habits such as thumb sucking?	☐	☐
Grinding his/her teeth?	☐	☐

What is your reason for seeking dental care? ____
How do you think your child will act at the Dental Office ____

Please check appropriate box as to how you intend to pay for your treatment:

[ ] Medicaid   [ ] CHP+   [ ] Private Dental Insurance   [ ] Credit Card   [ ] Check   [ ] Cash

Insurance Co____________________ **Policy #** ____________ **Group #** ____________ **Policy Holder** _________________________

Consent and Authorizations

I agree to be responsible for all charges for dental services and materials not paid by my dental benefit plan, unless prohibited by law, or the treating dentist or dental practice has a contractual agreement with my plan prohibiting all or a portion of such charges. To the extent permitted by law, I consent to the use and disclosure of any protected health information to carry out payment activities in connection with any and all claims. I hereby authorize and direct payment of the dental benefits otherwise payable to me, directly to MOD LLC/ KidsFirst Dental. Furthermore, I agree to be responsible for any bill incurred on this child for dental treatment, regardless of insurance coverage.

Financial Responsibility

In consideration of the professional services rendered to my child, I agree to accept responsibility for the payment of such services, if or when my insurance coverage denies such coverage. I agree to pay all legal costs including collection fees and attorney fees if I fail to pay my account. I grant you, or your assigned, permission to telephone me at home, my work or my mobile device to discuss matters related to this form and any outstanding account balance.

Doctor/Patient Relationship Termination

The Doctor/ Patient relationship will terminate when the patient has reached 19 years of age. Emergency dental care will be available for 30 days following the patient's 19th birthday. KidsFirst Dental reserves the right to terminate the Doctor/Patient Relationship at any time and for any reason, other than as prohibited by law.

Parent/Guardian Escort Policy

A parent or guardian must be present in the building during all appointments. Only a parent or guardian can escort a patient to any appointment, unless a Release of Consent for Treatment has been completed by the parent or legal guardian.

I have completed the Health History to the best of my knowledge, have read and understand the Consent and Authorizations statements and Office Policies above and have no further questions.

Signature of Parent/ Legal Guardian: ____________________________________ Date: ______________________________