CAPSTONE KIDS
Pediatric Dentistry

Today's Date ___/____/_____

Child's Name:_____
Last **First** **M.I.**

Child's Preferred Name_____ ❑Boy ❑Girl

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

Child's Social Security:_____

Child's Address:_____
Home Address

_____
City **State** **Zip**

How were you referred to our office?

❑Pediatrician ❑Dentist ❑Friend ❑Yellow Pages
❑Facebook ❑Google ❑Location ❑Other

If Friend, Pediatrician, Dentist or Other, please list:

Who is accompanying this child today?

_____ _____
Full name **Relation to child**

Do you have Legal Custody of this child? ❑ Yes ☐ No

Mother's Name: _____
❑ **Check if same as child's**

_____
Home address (If not same as child's)

_____ _____ _____
Mother's Social Security **Date of Birth** **Mother DL#**

Employer:_____

Father's Name:_____
❑ **Check if same as child's**

_____
Home Address (If not same as child's)

_____ _____ _____
Father's Social Security **Date of Birth** **Father DL#**

Employer:

Primary Insurance

Policy Holder Name: _____

Insurance Company Name: _____

Contract or ID Number: _____

Group Number: _____

Secondary Insurance

Policy Holder Name: _____

Insurance Company Name: _____

Contract or ID Number: _____

Group Number:
_____

Contact Information

Main cell Number: _____
❑ Mother ❑ Father
Accepts Texts?
❑Yes ❑No

Additional Cell Number: _____
❑ Mother ❑ Father
Accepts Texts?
❑Yes ❑No

Best Email Address to send you paperless statements:

_____

Is it ok for our office to send you paperless statements?
- ❑ **Yes**
- ❑ **No**

Child's Dental Information Preferred Name_____
Reason for today's visit: ❑Exam ❑Emergency ❑Consultation

Is child in pain? ❑No ❑Yes How long? _____

Within the past year have there been any changes in your child's general health? ❑Yes ❑No

What is the approximate date of your child's last medical exam?
___/___/___

Previous Dentist: _____

Last Dental Exam: _____/_____/_____ Last Dental X-rays:___/___/___

Is your child taking a fluoride supplement? ❑Yes ❑No

Does the child do any of the following? ❑Thumb/Finger Sucking ❑Tongue Thrusting ❑Heavy Snoring ❑Mouth Breathing ❑Lip Sucking/Biting ❑Grinding/clenching

What is child's favorite fluid to drink? ❑Water ❑Kool-Aid ❑apple juice ❑milk ❑formula ❑tea❑ soft drink❑ ❑other
If other, please list: _____

Patients who are 10 or more minutes late for their schedule appointment time will be rescheduled out of respect for our already scheduled patients who arrived on time for their appointments.

_____
Parent's Signature Date

DO NOT BREAK YOUR SCHEDULED APPOINTMENT!

A 48-hour notice is required to cancel or change an appointment. A $35 fee WILL be charged to you if an appointment is changed or cancelled without 48 hours notice.

_____
Parent's Signature Date

Mom's Email:_____

Dad's Email:_____

Child's Medical History

Are immunizations up to date? ❑Yes ❑No
Is child presently taking any medications? ❑Yes ❑No if yes, what: _____

Does child require pre-medication with antibiotic for treatment? ❑Yes ❑No
Had complications with or after treatment? ❑Yes ❑No if yes, please explain: _____

Child's Physician: _____ (____) _____
Doctor's Name or Clinic Name Phone#

Is child allergic to: ❑Latex ❑Penicillin/Amoxicillin ❑Nickel ❑Dental Anesthetics ❑Aspirin ❑Food allergies ❑Other?
If Other or Food Allergies, please list: _____

Does Child have or ever had any of the following diseases, medical conditions or procedures?

❑ Heart Murmur	❑ Surgeries/Operations	❑ Hemophilia/Abnormal Bleeding
❑ Artificial Heart Valves	❑ Tonsillitis	❑ Diabetes/Hypoglycemia
❑ Congenital Heart Defect	❑ Liver Problems	❑ Blood Transfusion (s)
❑ Physically Challenged	❑Seasonal Allergies	❑Speech/Hearing
❑Down Syndrome	❑ Kidney Problems	❑ Chemotherapy
❑ Cerebral Palsy	❑ Lung Problems	❑ Brain Injury
❑ Psychiatric Problems	❑ Asthma/Difficulty Breathing	❑ Cleft Lip/Palate
❑ Birth Defect	❑Respiratory Problems	❑ Jaw Problems TMJ/TMD
❑Autism	❑ Tuberculosis (TB)	❑ Sickle Cell or Trait
❑Fainting	❑ Leukemia	❑ Rheumatic Fever
❑ Epilepsy	❑ Cancer/Tumors	❑ ADD/ADHD
❑ Seizures	❑ Anemia	❑ HIV/AIDS/ARC

Please list any other medical condition(s) child has or ever had including previous hospitalizations:

_____

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my child's health.

Parent Signature: _____Date_____ **Staff Signature: _____Date**

Doctor Signature _____Date_____

FINANCIAL POLICY

We are pleased that you have chosen us for your child's dental care. We want to establish a long and pleasant relationship with you and your child. We understand that the filing of dental insurance can be a very complicated and time-consuming task. We want to assist you in any way possible to receive the maximum benefit from your insurance. We need your understanding and cooperation in the following guidelines regarding the filing of your insurance claims and payment.

1. **We are contracted as a *preferred* provider for the following insurance companies:**
   - ☐ **Blue Cross Blue Shield of Alabama**
   - ☐ **Delta Dental**
   - ☐ **Medicaid**
   - ☐ **Southland**

All applicable deductibles, co-payments, and co-insurance amounts are due at the time **services are rendered**. We accept cash, check, Master Card, Visa, Discover and American Express. Some dental services may not be covered by your contract. In the event a given procedure is not covered, payment for these services is your responsibility. In the event the balance is unpaid and turned over for collections, any and all indebtedness such as reasonable collection fees, attorney fees and court costs will be added to the account and is your responsibility.

IF YOUR INSURANCE IS NOT WITH ONE OF THE ABOVE COMPANIES, PLEASE SEE FOLLOWING PARAGRAPH.

2. **If your insurance is through a company with whom we are not contracted:**

☐ Please check your contract carefully to determine if you are required to see a preferred provider for that company. **Understand that if you choose to see a non-preferred provider, your insurance may not pay the full amount or pay at all.**

☐ Your insurance is a contract between you and your insurance company. Our office is not a part to that contract.

☐ While the filing of insurance claims is a courtesy that we gladly extend to you, **ALL CHARGES ARE ULTIMATLEY YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED.**

In order to facilitate accurate and prompt reimbursement, we request that you give us complete and correct information. If you have any questions regarding your insurance coverage or our financial policy, please do not hesitate to ask. We are happy to help you and appreciate your cooperation. Again, we are very thankful you have chosen us to be your child's dental care provider.

By my signature, I acknowledge that the above insurance policy has been thoroughly explained to me and I understand and agree to comply with said policy. I understand that I am financially responsible for any outstanding balance for services provided that are not fully covered by insurance and I will be billed for this remaining balance. I consent and agree to be financially responsible for payment of all services rendered on behalf of my children/dependent.

Signature of Responsibility Party _____ Date _____

PATIENT HIPAA CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

- **Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment):**
- **Obtaining payment from third party payers (e.g. my insurance company);**
- **The day-to day healthcare operations of your practice.**

I have also been informed of, and given the right to review and secure a copy of your *Notice of Privacy Practices*, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment, and healthcare operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

ADA Guide for Compliance with "The New Red Flags Rule For Protection Of Identify Theft And Detection Response Program" are in place.

I understand that I may revoke this consent, in writing, at anytime. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Print Patient Name _____

Signature: _____

Please list the Name and Relationship of person(s) with permission other than parent/legal guardian to accompany patient to appointments. The person(s) listed can make decisions about treatment administered at this visit or any future visits, can also make changes to appointments and will be responsible for any co-payments due at the time of the appointment.

Name/Relationship_____Date_____

Office Personnel_____Date_____

INFORMED CONSENT

Thank you for choosing us as your dental care provider. We will make every effort to ensure that your child has a pleasant dental experience. On his/her initial visit, he/she will see one of our dental hygienists to have his/her teeth cleaned. Usually by age 1, we will begin fluoride treatments. We usually begin dental radiography (x-rays) at age 3-4. Bitewings or cavity detecting x-rays are recommended at least yearly to check for cavities between the back teeth (molars). If a patient has a high incidence of dental decay, we may repeat these x-rays at their 6-month recare visit. Once a child reaches the age of 5, we generally take a panoramic x-ray of the entire mouth to check the position of permanent teeth and check for missing teeth or other pathology. This x-ray is usually repeated at 3-year intervals. Following the visit with the hygienist, our doctor will examine and discuss all oral findings with you, address any concerns you may have, and make recommendations for future treatment. We again thank you for the privilege of having your child as a patient.

I understand the risks and benefits of these procedures and give my consent for our doctor and staff to complete the above procedures on my child as necessary. I also understand the risks and benefits of not completing the above procedures. I acknowledge that all of my questions have been answered to my satisfaction and I request to proceed. Any procedures that you do NOT wish to be completed on your child, please notify a staff member.

By my signature I acknowledge that I read the above, and that the procedures have been explained to me. I authorize the diagnosis of my child's dental health by means of radiographs, study models, or other diagnostic aids deemed appropriate

_____Date_____

Signature of Parent or Guardian