CHILDREN'S DENTAL WORLD
smiles in any language

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 preventative care. We strive to teach 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: _____

Child's Home Phone #: _____

Child's Home Address: _____

_____

_____
City State Zip

General Information

Who is accompanying the child today? _____

Do you have legal custody of this child? ___ Yes ___ No

How did you hear about our office? _____

Other sibling(s) seen by us: _____

Previous/Present Dentist: _____ Last Visit Date: _____

Dentist's Phone #: _____

Relative or Friend not living with you:

Name: _____ Phone: _____

Address: _____

_____
City State Zip

Parents' Information

Person responsible for account: _____

____ Father ____ Stepfather ____ Guardian

Name: _____ Birthdate: ___/___/___

Address: (if different than Child's) Home #: _____

_____

_____

SS #: _____

Work #: _____ Ext: ___ Cell #: _____

Email: _____

Employer: _____

Parents' Martial Status: ____ Single ____ Married ____ Widowed ____ Divorced ____ Separated

____ Mother ____ Stepmother ____ Guardian

Name: _____ Birthdate: ____/____/_____

Address: (if different than Child's) Home #: _____

_____

_____

SS #: _____

Work #: _____ Ext: ____ Cell #: _____

Email: _____

Employer: _____

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 co-payment 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 & Medical History

Why did you bring your child to the dentist today?

_____

_____

_____

Is your child currently in pain? ___Yes ___No

How often does your child brush his/her teeth daily? ___

What type of toothpaste does he/she use?

__with Fluoride __Fluoride free (toddler) __Don't know

Does your child floss his/her teeth daily? ___Yes ___No

Is child currently under care of a physician? __Yes __No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

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

_____

_____

_____

Is your child allergic to any of the following? __Yes __No

____ Latex ____ Metal/Nickel

____ Penicillin ____ Other- Please list: _____

_____

_____

Has your child experienced the following medical problems?

Y	N	ADD /ADHD	Y	N	Hepatitis
Y	N	AIDS/HIV Positive	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	HIV Exposure (but negative)
Y	N	Artificial Heart Valve	Y	N	Hives or Rash
Y	N	Artificial Joint	Y	N	Kidney Problems
Y	N	Asthma	Y	N	Measles
Y	N	Autism	Y	N	Mitral Valve Prolapse
Y	N	Cancer	Y	N	Mononucleosis
Y	N	Chemotherapy	Y	N	Psychiatric Care
Y	N	Chicken Pox	Y	N	Rheumatic Fever
Y	N	Congenital Heart Defect	Y	N	Scarlet Fever
Y	N	Developmental Delays	Y	N	Sensory Processing Disorder
Y	N	Diabetes	Y	N	Sickle Cell Disease
Y	N	Epilepsy or Seizure	Y	N	Speech Delays
Y	N	Excessive Bleeding	Y	N	Tonsillitis
Y	N	Handicaps	Y	N	Tuberculosis
Y	N	Hearing Impaired	Y	N	Tumors
Y	N	Heart Murmur	Y	N	Ulcers

Has your child had any illness not listed above?

____ No

____ Yes (please list) _____

Is the child's immunizations current? ____Yes ____No

Has your child ever had to stay in the hospital or had an operation?

____ No

____ Yes (please list) _____

Does your child currently:

Y	N	Breast Feed	Y	N	Sleep with Sip Cup
Y	N	Clench/Grind Teeth	Y	N	Take Gummy Vitamins
Y	N	Drink Tap Water	Y	N	Thumb/Finger Suck
Y	N	Sleep with a Bottle	Y	N	Use a Pacifier

Our office is HIPAA compliant and is committed to meeting/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. I understand that providing incorrect information can be dangerous to my child's health, and it is my responsibility to inform the dental office of any changes in medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____

Signature of Parent or Guardian Date

The Parent or Guardian who accompanies the child is responsible for payment at time of service unless prior arrangements have been approved.

Permission for Dental Treatment

I give my permission for Children's Dental World, LLC to perform all necessary procedures to render treatment for my child. Some procedures that may be used include (but are not limited to): (1) the use of physical restraints (the Papoose System) to prevent possible injury to the child; (2) the use of mouth props, which gently prevents the child's mouth from closing; (3) the use of accepted behavior management techniques to control inappropriate behavior during dental treatment (examples of these include, but are not limited to: "tell, show, do", "voice control", "distractions", "positive reinforcement"); and (4) the use of nitrous oxide and oxygen (laughing gas). The use of the Papoose System and nitrous oxide will only be used after receiving verbal consent from the parent/guardian.

All questions and concerns regarding this permission statement have been explained to my satisfaction by the staff at Children's Dental World, LLC. I understand that all of the methods listed above are approved by the American Academy of Pediatric Dentistry.

I fully understand this permission statement and consent to the use of the procedures stated above if deemed necessary by Children's Dental World, LLC.

Cancellation Policy

Please be courteous to other patients who are on a wait list and request any cancellation of scheduled appointments at least 24 hours in advance. If your child fails to appear for a scheduled appointment or you have to cancel a scheduled appointment less than 24 hours remaining until the beginning of the appointment, please note that you will be charged a $50.00 missed appointment fee and the next available time for your child's rescheduled appointment could be in a few weeks.

Please sign and date below to acknowledge your permission for dental treatment and the cancellation policy for the office.

Date: _____

Child's Name:_____

Parent/Guardian's Signature:_____

Insurance / Payment Policy

We attempt to estimate your insurance benefits as accurately as possible. Some insurance companies, however, may have exclusions or exceptions unique to your policy. These exceptions may result in an insurance payment that is different from what we originally estimated. If the insurance company pays more than we estimated, a refund will be given to you from our office. If the insurance company pays less than we estimated, an additional payment will be due from you to Children's Dental World, LLC.

Dental insurance policies may be a bit complicated, but it is ultimately your responsibility to understand how they can benefit you. We are here to help, but please understand that we are estimating what your dental insurance benefit will be. As a courtesy, Children's Dental World, LLC will file the insurance claim for you and gladly file any secondary insurance claim as well. However, third party insurance coverage is the responsibility of the insured.

Some insurance companies require periodic information updates to be filled out and will mail these forms directly to you. Please be aware that your insurance company will not process any claims if they do not receive a completed update form back from you. You can call your insurance company directly with inquiries regarding any updates.

Please sign and date the bottom portion of this form indicating that you understand the way our office handles insurance and billing. If someone other than yourself is responsible for payment, please have them review and sign.

I understand that payment for services is due at the time that treatment is rendered. I also understand that Children's Dental World, LLC is estimating what my dental insurance will cover, but ultimately, I am responsible for any balance due.

Signature: _____ Date: _____

Acknowledgement of Receipt Of Notice of Privacy Practices

I have received a copy of this office's Notice of Privacy Practices. If I am a minor unaccompanied by a parent or guardian, I will accept this Notice and provide it to my parent or guardian.

_____
Please print name

_____
Signature

_____
Date

For Office Use Only - For Office Use Only - For Office Use Only - For Office Use Only

The patient was offered a copy of the Notice of Privacy Practices. An attempt was made to obtain a signature on this Acknowledgement of Receipt for the notice. It could not be obtained because:

- ☐ Individual refused to sign.
- ☐ Parent stated that a copay was received previously prior to treatment of sibling.
- ☐ Communications or language barrier.
- ☐ Emergency situation prevented obtaining acknowledgment.
- ☐ Other (Specify below).

Received by _____Date_____
Staff Member