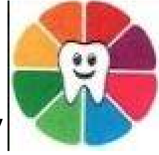
Kaleidoscope Kids Dentistry



PATIENT INFORMATION

Date:_________________

Name: (Last)_________________________ (First)_________________________ (MI)_____(Preferred)____________

Gender: (M / F) Date of Birth: _______________. Social Security #____________________

Address: _____________________________________ (City, State) ______________________ (Zip) ____________

Phone: (Home) _____________________ (Cell)______________________ Email:____________________________

Text Reminders: (Yes / No) Pharmacy: ____________________________________

Emergency Contact: ___________________________ Phone: ___________________ Relationship ______________

*How did you hear about us? ____

RESPONSIBLE PARTY

☐ Same as above

Name of Person Responsible for this Account: ____________________________________ DOB: __________________

SSN: ________-________-___________ Relationship to Patient: ____

Address: __________________________________ City: _____________________ State: ______ Zip:___________

Phone: ____________________________________ E-Mail: ____

Employer: ____ Work Phone:______________________________

INSURANCE INFORMATION

☐ No Insurance

Insurance Company: _____________________________________ Insurance Phone #:______________________

Member ID #: __________________________________ Group #: ____

Policy Holder: ______________________________DOB: _____________Relationship to Patient: ______________

SSN: _______________________________. Employer: ____

* Do you have any additional insurance? (Yes / No)

Insurance Company: ____

Medical History

Date: ____________

MEDICATIONS		
☐ Blood Thinners/ Coumadin/ Aspirin	❑ AIDS/HIV Positive	❑ Head Injuries
☐ Phen-Fen/ Fosamax	❑ Anemia	❑ Heart Disease/Heart Attack
Please list ALL other medications	❑ Artificial Joint: DATE: ____________	❑ Heart Murmur
(Or provide a list)	❑ Artificial Heart Valve:	❑ Hepatitis/Jaundice
______________________________	❑ Asthma	❑ High Blood Pressure
______________________________	❑ Blood Disease	❑ Immune System Disorders
______________________________	❑ Cancer/Tumors	❑ Kidney/Renal Disease
______________________________	❑ Cold Sore	❑ Liver Disease
ALLERGIES	❑ Depression	❑ Low Blood Pressure
☐ Amoxicillin ☐ Tetracycline	❑ Diabetes/Low Blood Sugar	❑ Mental/Nervous Disorders
☐ Codeine ☐ Latex	❑ Dizziness	❑ Pacemaker
☐ Sulfa ☐ Penicillin	❑ Dry Mouth	❑ Pregnant- DUE: ________.
Other: ________________________	❑ Epilepsy/Seizures	❑ Sinus Problems
______________________________	❑ Excessive Bleeding	❑ Stomach Problems/Ulcers/GERD
______________________________	❑ Fainting	❑ Stroke
	❑ Hay Fever/Allergies	❑ Tuberculosis
		❑ Thyroid Condition
		❑ STD/Venereal Disease
		❑ Tobacco/Alcohol/Drug

Do you have or have you had any other diseases or medical problems NOT listed on this form? YES NO

If yes, please explain ____.

Do you require antibiotic **PRE-MEDICATION** for a heart condition, artificial calce or artificial joint? YES NO

Orthopedic Surgeon Name: ____.

Are you under the care of a medical doctor at this time or in the last 12 months? YES NO

Physician Name: ____.

If yes, please explain: ____.

(WOMEN) Are you Pregnant? YES NO Due date: ______________.

Nursing? YES NO Taking Birth Control Pills YES NO

OFFICE FINANCIAL POLICIES AND FEDERAL TRUTH-IN-LENDING STATEMENT

As a condition of your treatment by this office, financial arrangements must be made in advance. The practice depends upon reimbursement from our patients for costs incurred in their care to remain viable. Therefore, financial responsibility on the part of each patient must be determined before treatment.

All emergency dental services, or any dental services performed without precious financial arrangements must be paid for at the time services are rendered.

Patients who carry dental insurance understand that all dental services finished are charged directly to the patient and that he/she is personally responsible for payment of all dental services. This office will help prepare the insurance forms of our patients or assist in making collections from insurance companies and will credit any such collections received to the patients account. However, this dental office cannot render services on the assumption that our charges will be paid in full by an insurance company.

A service charge of 1.5% per month (18% per annum) on the unpaid balance will be assessed on all accounts exceeding sixy (60) days from the date of service unless previously written financial arrangements are made. I understand that the fee estimate listed for this dental care can only be extended for a period of six (6) months from the date of the patient examination.

In consideration for the professional service rendered to me (or at my request, to my minor child or ward) by the dentist, I agree to pay the fees charged for the dental services provided by the dentist or license employee at the time the services are rendered, or within five (5) days of billing if credit is extended by the dentist. In the event my account becomes delinquent, I agree to pay the remaining balance plus the sum of the collection commission, charged by the collection agency to which a delinquent account is turned for collection, in addition to reasonable attorney fees and court costs where such legal services are necessary. I authorize the release of financially identifiable information concerning my account, including charges billed, payments are made, and interest charges assessed, etc to the dentist's collection agency or attorney should collection procedures as described become necessary.

I grant my permission to you and your assignee to contact me at home or at my workplace to discuss matters related to this form. I also agree to let this office leave messages concerning appointments and /or results on my answering machine or with a family member.

This agreement supersedes all prior agreements signed, including any and all mediation or mediation/arbitration agreements. I acknowledge that any prior mediation or mediation/arbitration agreements signed previously related to financial arrangements or quality of care are null and void.

I authorize the dentist or his designees to release financially identifiable information and treatment descriptions and information, either electronically, by facsimile or in paper form to my insurance carrier or any related entities that require such information to be submitted.

I acknowledge that I have received a copy of this office's Privacy Policies. I agree to disclose to the dentist names of individuals with whom I authorize the dentist to discuss my dental care.

I certify that I have answered all questions on both sides of this form accurately and to the best of my knowledge. I hereby agree to abide by the conditions outlined herein.

I have read the OFFICE FINANCIAL policy and HIPAA policy page provided by Kaleidoscope Kids Dentistry.

______________________________	________________	______________________
Signature of Patient or Guardian	Date	Relationship