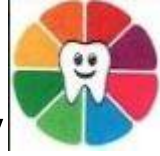


# Kaleidoscope Kids Dentistry



## Información Del Paciente

Fecha:

Nombre: (Apellido) \_\_\_\_\_ (nombre) \_\_\_\_\_ (MI) \_\_\_\_\_ (Preferido)  
Genero: ( M / F ) Fecha de nacimiento: \_\_\_\_\_ Seguro social # \_\_\_\_\_  
Dirección: \_\_\_\_\_ (Ciudad, Estado) \_\_\_\_\_ (codigo postal)  
Numero: (Casa) \_\_\_\_\_ (Cell) \_\_\_\_\_ Email: \_\_\_\_\_  
Recordatorios de Texto: ( Si / No ) Pharmacia: \_\_\_\_\_  
Contacto de emergencia: \_\_\_\_\_ Tel.: \_\_\_\_\_ Relation \_\_\_\_\_  
\*Cómo te enteraste de nosotros? \_\_\_\_\_

## Fiesta Responsable

La misma que arriba

Nombre de la persona responsable de esta cuenta: \_\_\_\_\_ fecha de nacimiento: \_\_\_\_\_  
SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ Relation a el paciente: \_\_\_\_\_  
Dirección: \_\_\_\_\_ Ciudad: \_\_\_\_\_ Estado: \_\_\_\_\_ Codigo postal: \_\_\_\_\_  
Numero: \_\_\_\_\_ E-Mail: \_\_\_\_\_  
Empleador: \_\_\_\_\_ número de trabajo: \_\_\_\_\_

## Information del seguro

No aseguranza

Compania de seguro: \_\_\_\_\_ Numero de seguro #: \_\_\_\_\_  
ID de miembro #: \_\_\_\_\_ # de grupo: \_\_\_\_\_  
Titular de la póliza: \_\_\_\_\_ Fecha de nacimiento: \_\_\_\_\_ Relation: \_\_\_\_\_  
SSN: \_\_\_\_\_ Empleador: \_\_\_\_\_  
\* ¿Tienes alguna otra aseguranza ? ( Si / No )

Compania de Aseguranza:

**Historial Medico**

Fecha: \_\_\_\_\_

**MEDICATIONES**

- Blood Thinners/ Coumadin/ Aspirin
  - Phen-Fen/ Fosamax
- Please list ALL other medications  
(Or provide a list)

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**ALLERGIAS**

- Amoxicillin     Tetracycline
- Codeine         Latex
- Sulfa             Penicillin

Other: \_\_\_\_\_

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- Head Injuries
- Heart Disease/Heart Attack
- Heart Murmur
- Hepatitis/Jaundice
- High Blood Pressure
- Immune System Disorders
- Kidney/Renal Disease
- Liver Disease
- Low Blood Pressure
- Mental/Nervous Disorders
- Pacemaker
- Pregnant- DUE: \_\_\_\_\_.
- Sinus Problems
- Stomach Problems/Ulcers/GERD
- Stroke
- 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? SI NO  
If yes, please explain \_\_\_\_\_.

Do you require antibiotic **PRE-MEDICATION** for a heart condition, artificial calce or artificial joint? SI NO  
Orthopedic Surgeon Name: \_\_\_\_\_.

Are you under the care of a medical doctor at this time or in the last 12 months? SI NO  
Physician Name: \_\_\_\_\_.  
If yes, please explain: \_\_\_\_\_.

<b>(MUJER)</b> Esta Embarazada?	SI	NO	fecha de vencimiento: _____.
Nursing?	YES	NO	Taking Birth Control Pills <span style="margin-left: 20px;">YES</span> <span style="margin-left: 20px;">NO</span>

**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 sixty (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.

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Signature of Patient or Guardian

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Date

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Relationship