

# General Dentistry 4 Kids

Thank you for choosing General Dentistry 4 Kids to serve you in your dental care. We look forward to providing you with dental service and treatment.

In order to provide you with the outmost in dental care, we would like to establish some guidelines.

**Courtesy Reminders:** The day before your appointment we will call you to remind you of your appointment. Please keep in mind that this is provided as a **courtesy only** and that you (patient/parent/guardian) are **ultimately responsible** for keeping your appointment.

**Cancellation Policy:** We require a 24-hour advance of cancellation. If you are unable to make your appointment, please call us to let us know so that other patients who are in need of treatment can be scheduled accordingly.

**Failed appointments:** Patients who do not show up to their scheduled appointments without 24 hour notification, will be considered missed/failed appointments. After 3 missed appointments, patients will need to seek dental treatment through another dental provider.

**Tardiness:** Patients who are more than 15 minutes for their appointment will not be seen and will need to be rescheduled. Treatment will be rendered at the discretion of the dental provider.

**Family member appointments:** Only two (2) members of a family will be scheduled on the same day for treatment. This helps us limit the amount of missed appointments. We apologize for any inconvenience this may cause.

**Financial Policy:** Our office will be happy to submit any insurance claims for your child. Any co pays, deductibles, or known percentages need to be paid the day of service. However, please remember that in most cases these figures are only estimates. We will also be happy to pre-authorize any treatment through your insurance company. We cannot guarantee what your insurance will pay. You will be responsible for any services not covered by your insurance carrier. Due to the large volume of patients that we care for, we will be unable to make any calls to your insurance company on your behalf.

I agree to pay all finance charges, collection costs of 33%, attorney fees and all other costs that may incur to enforce collection of any amounts outstanding.

I acknowledge that I have read, understand, and am willing to comply with the above financial responsibility.

Thank you for your time and cooperation in this manner. We look forward to serving you in your dental care.

Patient/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# General Dentistry 4 Kids

## Pediatric Dental Treatment Consent Form

I understand that the normal procedures for a first time patient may include a comprehensive or limited exam, dental cleaning, fluoride applications, sealants and radiographs (x-rays) as necessary. However, this is subject to change depending on the numerous factors including patient's behavior, amount of future work and time. I also understand that all treatment, alternative methods of treatment, as well as the advantages and disadvantages of each will be explained to me.

In general terms the procedures that your child may need include:

- A. Applications of sealants
- B. Root canals (permanent teeth) or pulpotomies (primary teeth)
- C. Porcelain crowns or stainless steel crowns
- D. Restoration of broken teeth or fillings
- E. Treatment of infected teeth or gums
- F. Extractions of 1 or more teeth
- G. Use of supports to safely perform necessary dental procedures
- H. Use of nitrous oxide to help reduce anxiety as needed
- I. Use of local anesthetics, oral anesthesia or oral sedatives as needed

We will advise you that although the best results are expected, there is no way within reason, of anticipating complications. Therefore, it is not possible to guarantee the results of the treatment. Although the occurrence is remote, it is known that some risks are associated with dental procedures. For example bleeding, swelling, numbness, discoloration, nausea, vomiting and allergic reactions may be associated with such procedures and complications may require hospitalization.

I have read and understand what has been reviewed in this consent form, and that all questions about the procedure or procedures have been answered in a satisfactory manner. I also understand that I have the right to be provided with answers to questions which may arise during the course of treatment.

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Parent or Guardian's signature

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Date

# General Dentistry 4 Kids

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such Notices of Privacy Practices prior to signing this consent. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

In the event that I may not be present for my child's appointment, I, \_\_\_\_\_, give permission for the following adult(s) to make decisions concerning my child's dental treatment and financial payment. Please print.

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Patient Name: \_\_\_\_\_

Parent/Guardian Signature: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

Date: \_\_\_\_\_

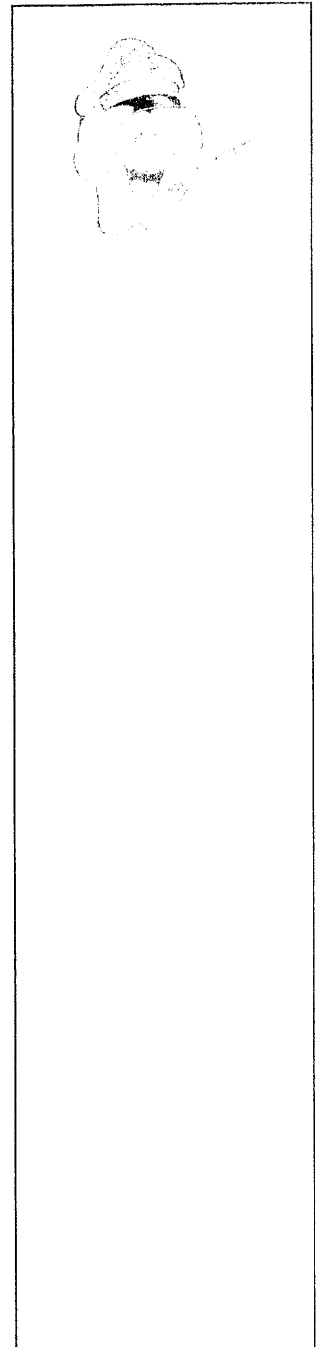
Patient's Name \_\_\_\_\_  
 Patient's SSN \_\_\_\_\_  
 Patient's Birthdate \_\_\_\_\_  
 Patient's Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home# \_\_\_\_\_  
 Cell phone \_\_\_\_\_  
 Sex: Female \_\_\_\_\_ Male \_\_\_\_\_  
 Emergency Contact \_\_\_\_\_  
 Phone# \_\_\_\_\_

Resp. Party's Name \_\_\_\_\_  
 Resp. Party's SSN \_\_\_\_\_  
 Driver's License \_\_\_\_\_  
 Resp. Party's Birthdate \_\_\_\_\_  
 Resp. Party's Employer \_\_\_\_\_  
 Work# \_\_\_\_\_  
 Insurance Carrier \_\_\_\_\_  
 Military Rank \_\_\_\_\_  
 AHCCCS Plan \_\_\_\_\_  
 Email: \_\_\_\_\_

HOW DID YOU HEAR ABOUT US?

DO YOU HAVE OTHER DENTAL COVERAGE? YES NO

1. Are you under a physician's care? Physician's name \_\_\_\_\_ yes no  
 Since when? \_\_\_\_\_ Why? \_\_\_\_\_
2. When was your last physical exam? \_\_\_\_\_
3. Are you taking any medication or substances? What? \_\_\_\_\_ yes no
4. Are you allergic to any medication or substances? What? \_\_\_\_\_ yes no
5. Do you have any problems with penicillin, antibiotics, local anesthetics (Novocaine) or other allergies? \_\_\_\_\_ yes no
6. Do you have any other allergies? To what? \_\_\_\_\_ yes no
7. Are you sensitive to any metals or latex? \_\_\_\_\_ yes no
8. Are you pregnant or suspect you are? \_\_\_\_\_ yes no
9. Do you take birth control medications? \_\_\_\_\_ yes no
10. Have you ever been treated for heart disease? \_\_\_\_\_ yes no
11. Do you have a pacemaker or an artificial heart valve implant? \_\_\_\_\_ yes no
12. Have you ever had rheumatic fever? \_\_\_\_\_ yes no
13. Are you aware of having a heart murmur? \_\_\_\_\_ yes no
14. Do you have high blood pressure? \_\_\_\_\_ yes no
15. Have you ever had a serious illness or major surgery? \_\_\_\_\_ yes no
16. Have you ever had radiation treatment, chemotherapy, or any other? \_\_\_\_\_ yes no
17. Do you have soreness, clicking, or popping in your jaw joint? \_\_\_\_\_ yes no
18. Do you have any blood disorders such as anemia, leukemia, hemophilia, etc? \_\_\_\_\_ yes no
19. Do you have any artificial joints/prosthesis? \_\_\_\_\_ yes no
20. Have you ever bled excessively after being cut or injured? \_\_\_\_\_ yes no
21. Have you ever received a blood transfusion? \_\_\_\_\_ yes no
22. Do you have kidney problems? \_\_\_\_\_ yes no
23. Do you have stomach problems? \_\_\_\_\_ yes no
24. Do you have any liver problems? \_\_\_\_\_ yes no
25. Are you diabetic? \_\_\_\_\_ yes no
26. Do you have asthma? \_\_\_\_\_ yes no
27. Are you HIV positive? \_\_\_\_\_ yes no
28. Do you have AIDS? \_\_\_\_\_ yes no
29. Have you had or do you test positive for hepatitis? \_\_\_\_\_ yes no
30. Did you read this question? \_\_\_\_\_ yes no
31. Do you or have you had tuberculosis? \_\_\_\_\_ yes no
32. Do you smoke, chew, use snuff or any other forms of tobacco? \_\_\_\_\_ yes no
33. Do you consume alcoholic beverages? \_\_\_\_\_ yes no
34. Do you habitually use controlled substances? \_\_\_\_\_ yes no
35. Is there anything else we should know about your health that we have not covered in this form? \_\_\_\_\_ yes no



\* I hereby authorize treatment and the use of nitrous oxide, anesthesia, oral sedation and/or other medications necessary for dental treatment.

\* The parent or guardian is required to remain in the DENTAL OFFICE during their child's dental treatment!

Initial Visit \_\_\_\_\_  
 Patient's (Guardian) Signature \_\_\_\_\_

Date \_\_\_\_\_

Reviewed By \_\_\_\_\_