Chart #:___________
FOR OFFICE USE ONLY

Patient Information

Patient Name: ____ Date:_______________
Last First

☐ Male ☐ Female ☐ Child ☐ Other_____________

Social Security #: ______________________________ Birth Date: ___________________________

Phone (Home): ______________________ Mobile #: ____

Address: ____
Street

____
City State Zip Code

Health Information

Date of Last Dental Visit: _________________ Reason for this visit:_________________________________

Has your child ever had any of the following? Please check those that apply

☐ Acid Reflux
☐ AIDS/HIV
☐ Allergies Environmental
____
☐ Allergies Drug
____
☐ Latex Allergy
☐ ADD
☐ ADHD
☐ Anemia
☐ Artificial Joints
☐ Asperger's Disorder
☐ Autism
☐ Artificial Joints

☐ Asthma
☐ Autoimmune Disorder
☐ Blood Disease
☐ Cancer
☐ Crohn's Disease
☐ Diabetes Type _____
☐ Epilepsy
☐ Excessive Bleeding
☐ Head Aches
☐ Head Injuries
☐ Heart Disorders
☐ Heart Murmur/MVP
☐ Premed Required
☐ Premed NOT Required

☐ Hay Fever-Seasonal
☐ Hi/Lo Blood Pressure
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Radiation/Chemo
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Sleep Problems
☐ Sensory Disorders
☐ Speech Delay
☐ Sinus Problems
☐ Stomach Problems

☐ Thyroid Problems
☐ Thumb Sucking
☐ Past ☐ Presently
☐ Tuberculosis
☐ Tumors/Growths
☐ Venereal Disease
OTHER:
☐ _________________
☐ _________________

- Has your child ever had any complications following dental treatment? ☐ Yes ☐ No
  If yes, please explain:____
- Has your child been admitted to a hospital or needed emergency care during the past two years? ☐ Yes ☐ No
  If yes, please explain:____
- Is your child now under the care of a physician? ☐ Yes ☐ No
  If yes, please explain:____
  Is your child currently up to date on all immunizations? _________________
  If no, please explain ____
- Name of Pediatrician: ____ Phone:__________________
- Does your child have any health problems that need further clarification? ☐ Yes ☐ No
  If yes, please explain:____

Is your child currently taking any medications? ____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

____ Date:______________________
Signature of patient, parent or guardian

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend, relative ☐ Dental Office

☐ Internet ☐ Yellow Pages ☐ Magazine ☐ School ☐ Direct Mailer ☐ Other_________________

Name of person or office referring you to our practice: ____

Responsible Party Information

The following is for: ☐ the patient's parent ☐ the person responsible for payment

Name: ______________________________

☐ Male ☐ Female ☐ Married ☐ Single ☐ Child ☐ Other ______________

Social Security #: ______________________________ Birth Date: ______________________________

Phone (Home): ________________ (Work): ________________ Ext:______

E-Mail ______________________________ Cell # ______________________________

Address: ______________________________
Street Apartment #

____
City State Zip Code

Parent/Guardian Employment Information

The following is for: ☐ the patient ☐ the person responsible for payment

Employer Name:______________________________ Occupation: ______________________________

Address: ______________________________
Street City State Zip Code

Insurance Information

Primary

Name of Insured: ______________________________
Last First MI

Insured's Birth Date: __________________ ID #: ______________________ Group #:______________________

Insured's Address: ______________________________
Street City State Zip Code

Insured's Employer Name: ______________________________

Address: ______________________________
Street City State Zip Code

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other____________________

Insurance Plan Name and Address: ______________________________

____

Facts about Dental Insurance: We ask that you realize that we don't work for a dental insurance company. Rather, we work 100% for our patients. We feel that dental insurance can be a great benefit for many patients and want you to know we will do everything in our power to insure you get every benefit allotted in your insurance contract. ***The treatment we recommend and the fees we charge will always be based on your child's individual needs, not your insurance coverage***.
Your insurance is based on a contract between the employer and the insurance company. We are not part of the contract; and, therefore, not responsible for the terms and/or benefits of your insurance company. Honoring and processing insurance benefits is done as a courtesy to the patient. Dental insurance benefits differ greatly from traditional health insurance. Dental insurance is never a **"pay all"** solution, but merely an aid. Many plans tell their patients services will be covered at "100%, 80% or 50%," but do not clearly specify plan fee allowances, annual maximums and limitations. It is more realistic to expect some out of pocket expense to be incurred with most visits to our office. Please ask for plan specifics from our insurance coordinator should you have specific treatment recommendations made by Dr King. Many routine dental services and x-rays are not covered by insurance companies. This does not mean the treatment is not necessary or appropriate; just simply not covered. In some cases, your benefits have specific limitations based on the number or frequency of services your plan will cover. Dr King may ask for x-rays or diagnostic aids more frequently than your annual benefits allow. *We do not provide average dentistry, and we will not recommend treatment or care regulated by your insurance contractual limitations.*

_____I authorize release of information to all my insurance carriers.

_____I understand that I am responsible for any part of my bill not covered by insurance.

_____I authorize payment directly to the doctor.

_____I authorize my doctor to act as my agent in helping me obtain payment from my insurance.

______________________________ ________________ ______________________________
Signature of patient, parent or guardian Date Relationship to Patient

Consent for Services

I understand that I am responsible for all charges incurred by me or a family member regardless of insurance coverage and **PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED**. If my account requires servicing by a collections agency or by an attorney, I understand that I will be liable for all collection fees, attorney fees and applicable court costs, in addition to my outstanding balance. I also request that payment under my dental insurance program be made directly to Daniel A. King, DDS, D.B.A The Children's Dental Zone on any unpaid bills for services. I authorize the release of any dental information necessary to process this and all future claims. The understood business policy is such that the parent or guardian who requests treatment for a child is responsible for all fees for services rendered.

I give Dr King and his office staff permission to use such measures as deemed necessary in their professional judgment to render a diagnosis for my child. This would include, but not be limited to an oral examination, prescribed radiographs (x-rays), prophylaxis, fluoride treatment and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have reported any prior allergic/unusual reactions, abnormal bleeding and other conditions related to my child's health and or physical conditions that my child's medical doctor has advised me to report the dentist.

HIPAA Notification: I have read and understand the Notice of Privacy Practices for The Children's Dental Zone.

I acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give informed consent. I further understand this consent shall remain in effect until terminated in writing by me.

____ Date: _____________ Relationship to Patient: ____________
Signature of patient, parent or guardian

____ Date: _____________ Relationship to Patient: ____________
Signature of guarantor of payment/responsible party

Broken Appointment Policy

Your child's scheduled appointment is reserved specifically for them. It is extremely important that all patients honor their reserved dental appointment. Failure to do so deprives other patients from receiving dental care in a timely fashion. We reserve the right to charge $50 for appointments that are cancelled or broken without 24 hours notice. Any broken appointment charges will need to be taken care of before you will be able to reschedule for another appointment. We understand that emergencies arise unexpectedly, and we will carefully assess each instance before applying any broken appointment fees. The charge associated with our office policy is to be paid within 30 days to prevent collection procedures. Multiple cancellations or broken appointments may result in dismissal from Children's Dental Zone.

I, the undersigned, have read and understand the broken appointment policy. I agree to any fees that are charged, should I fail to keep an appointment.

____
Signature of patient, parent or guardian

____
Date

____
Relationship to Patient