

# HEALTHY SMILES *for* Kids

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**ABOUT YOUR CHILD:**

Name: \_\_\_\_\_  
 Nickname: \_\_\_\_\_  Male  Female  
 Birthdate: \_\_\_\_\_  
 SSN: \_\_\_\_\_  
 Home Address: \_\_\_\_\_  
 \_\_\_\_\_  
 (Apt #) (City) (State) (ZIP)  
 Home Phone: \_\_\_\_\_  
 School: \_\_\_\_\_  
 Grade: \_\_\_\_\_  
 Child's Hobbies, favorite games: \_\_\_\_\_  
 \_\_\_\_\_

**ABOUT YOUR FAMILY:**

Email Address: \_\_\_\_\_  
Father's Information  
 Married  Single  Guardian  Step Father  Foster Parent  
 Name: \_\_\_\_\_  
 SSN: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_  
 Driver's License: \_\_\_\_\_ Exp: \_\_\_\_\_  
Mother's Information  
 Married  Single  Guardian  Step Father  Foster Parent  
 Name: \_\_\_\_\_  
 SSN: \_\_\_\_\_  
 Birth Date: \_\_\_\_\_  
 Employer: \_\_\_\_\_ Work Phone: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Alt Phone: \_\_\_\_\_  
 Driver's License: \_\_\_\_\_ Exp: \_\_\_\_\_  
 Brothers? \_\_\_\_\_ Age(s): \_\_\_\_\_  
 Sisters? \_\_\_\_\_ Age(s): \_\_\_\_\_

**DENTAL HISTORY:**

Is this your child's 1st dental visit? \_\_\_\_\_ If no, what was the approximate date of the last visit? \_\_\_\_\_  
 Has your child been seen by another dentist? \_\_\_\_\_ Name: \_\_\_\_\_  
 Was there a previous unfavorable medical/dental experience? \_\_\_\_\_ If so, please explain: \_\_\_\_\_  
 \_\_\_\_\_  
 Does your child receive fluoride tablets, drops, vitamins, or a rinse? \_\_\_\_\_  
 Does your child brush his or her teeth daily? \_\_\_\_\_ Do you assist them? \_\_\_\_\_  
 At what age was bottle or breast feeding stopped? \_\_\_\_\_  
 Does your child have any of the following?  Dental Pain  Swelling  Cavities  Sores in Mouth  Injured Teeth  
 Thumb/Pacifier  Sealants  Extracted Teeth  "Crooked Teeth"  Fillings  
 What do you predict your child's behavior to be?  Cooperative  Fearful  Defiant  Don't Know  
 What are your concerns about your child's teeth? \_\_\_\_\_  
 \_\_\_\_\_

**Does your child have any of the following habits?**

- Thumb/finger sucking
- Pacifier
- Lip sucking/biting
- Nail biting
- Nursing/bottle habits
- Mouth breathing
- Nighttime grinding of teeth

**REFERRAL INFORMATION:**

Whom may we thank for referring you to our practice?  
 Another Patient \_\_\_\_\_  
 Dental Office \_\_\_\_\_  
 Doctor's Office \_\_\_\_\_  
 Google  Drive By  School  Work  
 Other \_\_\_\_\_

**DENTAL INSURANCE:**

Dental Insurance Co. \_\_\_\_\_  
 Insurance Co. Phone # \_\_\_\_\_  
 Group: (Plan, Local or Policy) \_\_\_\_\_  
 Insured's Name: \_\_\_\_\_  
 Insured's DOB: \_\_\_\_\_  
 Insured's SSN: \_\_\_\_\_  
 Relationship to Patient: \_\_\_\_\_  
 Employer: \_\_\_\_\_  
 Employer's Address: \_\_\_\_\_  
 Employer's Phone Number: \_\_\_\_\_

*For our patients with dental insurance, we will be happy to file insurance claims for you as long as your insurance can be verified. We ask you to pay all non-covered fees as treatment progresses.*

Signature of Parent/Guardian \_\_\_\_\_

Date \_\_\_\_\_



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**MEDICAL HISTORY:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Anemia                         | <input type="checkbox"/> Diabetes                          | <input type="checkbox"/> Mental Emotional Problems  |
| <input type="checkbox"/> Asthma/Lung Problems           | <input type="checkbox"/> Ear Infections/Tubes              | <input type="checkbox"/> Pregnant                   |
| <input type="checkbox"/> Birth Defects                  | <input type="checkbox"/> Fainting Spells                   | <input type="checkbox"/> Premature/Low Birth Weight |
| <input type="checkbox"/> Bleeding Problems/Transfusions | <input type="checkbox"/> Hearing or Vision Loss/Impairment | <input type="checkbox"/> Psychiatric Problems       |
| <input type="checkbox"/> Blood Pressure Problems        | <input type="checkbox"/> Herpes                            | <input type="checkbox"/> Immunologic Disorders/HIV  |
| <input type="checkbox"/> Cerebral Palsy                 | <input type="checkbox"/> Kidney Disease                    | <input type="checkbox"/> Rheumatic Fever            |
| <input type="checkbox"/> Cleft Lip/Palate               | <input type="checkbox"/> Liver Disease/Hepatitis           | <input type="checkbox"/> Seizures/Epilepsy          |
| <input type="checkbox"/> Delayed Development            | <input type="checkbox"/> Malignancy, Cancer                | <input type="checkbox"/> Sickle Cell Anemia/Trait   |
| <input type="checkbox"/> Heart Problems/Murmurs         | <input type="checkbox"/> Latex Allergy/Sensitivity         | <input type="checkbox"/> Speech Problems            |
| <input type="checkbox"/> Other _____                    |  |   |

Pediatrician's name: \_\_\_\_\_ Last Visit: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Is your child allergic or had any adverse reaction to a medication? \_\_\_\_\_

If yes, please explain: \_\_\_\_\_

List any medications your child is currently taking, the dosage, and what it is taken for: \_\_\_\_\_

Has your child ever been hospitalized or treated in an emergency room? When? \_\_\_\_\_ Why? \_\_\_\_\_

**CONFIRMATION & MISSED APPOINTMENT POLICY**

We are dedicated to provide the best dental care possible for your child. We want to give your child the time and individual attention they deserve. In a sincere effort to acknowledge the importance of each parent's time, and to remain on time during our busy schedule, we must ask the parents to **ARRIVE ON TIME FOR THEIR CHILDREN'S APPOINTMENT**. This allows us to be able to see all the children that are scheduled in a timely and efficient way. When a parent is late or fails to make a scheduled appointment, this may jeopardize all the children's treatment. It also affects the other parent's schedules that have appointment times after your child that day.

- Please call our office if you are going to be late for your appointment.
- If a patient is more than 15 minutes late, we may need to reschedule the appointment. If we are able to see your child, we cannot guarantee that all treatment will be completed.

In an effort to serve all children that have dental needs, we must ask that you acknowledge our missed appointment policy. A time is specifically set aside for your child's dental appointment. Should you miss a restorative appointment, you will be assessed a "missed appoint" fee of \$30.00. At that time, you will be rescheduled for the missed appointment, and will be required to prepay your child's next appointment.

- Parents may change or cancel their child's appointment with at least 24 hours notice.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_



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OFFICE BILLING & INSURANCE POLICIES

Payments

Payments are due the day services are performed. Payment is accepted in the form of cash, check, debit cards, or credit cards (Visa mastercard, Discover or American Express). If you would like to keep an account on file with us, please fill in the appropriate information below.

Card #: \_\_\_\_\_ Expiration Date: \_\_\_\_\_ Vcode: \_\_\_\_\_

Insurance

Your insurance plan is an agreement between your insurance company and you. We file claims to your insurance company as a courtesy to you. After 30 days, we ask that you call your insurance company if no payment has been received. After 60 days, any outstanding insurance balance will be your responsibility. Also, please understand, you are responsible for the balance of charges incurred regardless of your insurance payment.

Billing

You may incur a finance charge of 1.5% on your account if your balance is not paid in 60 days or less. Please inform us of any financial concerns so an agreement can be made up front of how the account will be paid. I also agree that should it become necessary to forward my account for collections, in addition to the amount owed, I will also be responsible for the fees associated with the costs of collections.

Authorization

I have read and understand the above written financial policy; I hereby authorize payment of insurance benefits directly to Healthy Smiles for Kids, otherwise payable to me. I understand that I am ultimately responsible for all costs of dental treatment not covered by insurance. The responsible party is the parent/guardian that brings the child to the dental office and seeks treatment, independent of what a divorce decree may state. Reimbursement must be made between divorced parties; we will not intervene.

Signature \_\_\_\_\_ Date \_\_\_\_\_

HEALTH INFORMATION PRIVACY POLICY ACT (HIPPA)

Child/Children's Names: \_\_\_\_\_

Parent/Guardian's Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Address: \_\_\_\_\_

In general, the HIPPA privacy rule gives individuals the right to request a restriction of their health information. The individual is also provided the right to request confidential communications or that a communication of PHI (Protected Health Information) be made by alternative means, such as, sending information to the individual's office instead of their home.

I wish to be contacted in the following manner (check all that apply):

Home Telephone

Ok to leave message with details Ok to speak to spouse/sibling

Work Telephone

Ok to leave message with details Leave message with call back

Written Communication

Ok to mail to my home Ok to fax to designated number

I give Dr. Ritchie permission to use and disclose PHI necessary to carry out TPO (Treatment Payment or Operations). This is also indicated a "Good Faith Effort" was made on behalf of Dr. Ritchie. By signing this form, I understand that the privacy practices of this office have been disclosed to me. This information will stay on record for six years.

Signature \_\_\_\_\_ Date \_\_\_\_\_