JUST FOR KIDS PEDIATRIC DENTISTRY New Patient Registration Form

Today's Date: _____

Section 1: Tell Us About Your Child

Child's Full Name _____
Preferred Name _____ [ ] Male [ ] Female [ ] Other
Child's Birth Date _____/_____/_____ Age _____
School _____
Address _____
City _____ State _____ Zip _____
Hobbies/Interests/Pets: _____

Section 2: How Did You Hear About Us?

[ ] Google [ ] Family/Friend [ ] Insurance [ ] Facebook
[ ] Dentist [ ] Physician [ ] Yelp [ ] Other
Please List Name(s) of Referral Source so we may thank them

_____

Section 3: Contact Information

Best Contact Number _____
Alternative Number _____
Email _____

What is your appointment confirmation preference
(Please check all that apply):
[ ] Text [ ] Phone [ ] Email

Section 4: Responsible Parties

Name: _____[ ] Male [ ] Female
[ ] Parent [ ] Stepparent [ ] Legal Guardian [ ] Foster Parent
Date of Adoption, if applicable _____
Birth Date _____/_____/_____ SSN _____
Address (if not listed above)_____
Employer _____
Does this person hold insurance for this child? [ ] Yes [ ] No
Insurance Co. Name _____
Insurance Phone _____
Subscriber # _____

Additional Party Information:
Name: _____[ ] Male [ ] Female
[ ] Parent [ ] Stepparent [ ] Legal Guardian [ ] Foster Parent
Date of Adoption, if applicable _____
Birth Date _____/_____/_____ SSN _____
Address (if not listed above)_____
Employer _____
Does this person hold insurance for this child? [ ] Yes [ ] No
Insurance Co. Name _____
Insurance Phone _____
Subscriber # _____

Is your child currently a Mainecare member or have you applied for Mainecare Coverage? [ ] Yes [ ] No
If yes, provide copy of current card. ID # _____

Section 5: Are you on Facebook and/ or Instagram?

If your child has recently won one of our many contests or simply just had a great day, we'd love to brag about you to our friends and family!

So that our friends can like and share in your child's experience at our office, do we have your permission to use your child's picture on our facebook and Instagram page? Only first names will be used.

[ ] YES [ ] NO

Section 6: Accompanying Your Child

A parent or legal guardian must be present during all restorative treatment appointments unless the authorized person is listed below or a signed letter is provided.

Please list any person(s), other than legal parents/guardians, who are authorized to accompany your child and are authorized to make medical decisions on the legal guardians behalf.
Name _____Relation _____
Name _____Relation _____
(authorized person(s) must present proper identification upon arrival)

[ ] None; only legal parents/guardians may accompany

Consent for Dental treatment:
I am the parent, guardian, or personal representative of the patient and there are no court orders in effect that prevent me from signing this consent. I do hereby request and authorize the dental staff at Just For Kids Pediatric Dentistry, P.A. to perform the necessary dental services including but not limited to an examination, cleanings, any necessary dental treatment for my child's teeth, X-rays as necessary to diagnose and/or treat my child's dental problems, and administration of anesthetics that are deemed advisable by Just For Kids Pediatric Dentistry, P.A., whether or not I am present when the treatment is rendered. I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Our team will provide an environment that will help children learn to cooperate during treatment including praise, explanations and demonstrations of procedures and instruments.

_____
Parent/ Guardian Printed Name

_____ _____
Parent/ Guardian Signature Date

CHILD'S FULL NAME:_____

Section 7: Dental History

Why did you bring your child to the dentist today? _____
_____

Is this your child's first visit to the dentist? [ ] YES [ ]NO
If not, when was their last visit to the dentist?_____
Previous Dentist _____
Were x-rays taken at previous dental visits? [ ]YES [ ] NO
Have there been any injuries to the teeth, face or mouth?
[ ]YES [ ]NO
If yes, please explain:_____
Does your child have any of the following Habits?

Thumb / Finger Sucking Mouth Breathing

Lip Sucking / Biting Nail Biting

Nursing / Bottle Habits Pacifier use

Has your child ever had a serious or difficult problem associated with previous dental work? [ ]YES [ ]NO
If yes, please explain:_____
_____
Brushing:
Does your child brush his/her own teeth? [ ]YES [ ]NO
When does he/she brush? A.M. P.M. After Meals
Do you help in brushing your child's teeth? [ ]YES [ ]NO
How much toothpaste does your child use? _____
Does your child swallow toothpaste? [ ]YES [ ]NO
What kind of toothbrush does your child use?
Soft Hard Electric
Does your child know what floss is? [ ]YES [ ]NO
Does your child floss daily? [ ]YES [ ]NO
Fluoride:
Has your child had fluoride in any of the following forms:
Fluoride tablets, drops or fluoride multivitamins?[ ]YES [ ]NO
Drinking Water (community/tap water fluoridation) [ ]YES [ ]NO
Professional topical application? [ ]YES [ ]NO
Does your child use fluoride toothpaste? [ ]YES [ ]NO

Section 8: Health History

Does your child have any of the following conditions?

ADD/ADHD	Disabilities/Special Needs
AIDS/HIV+	Eating Disorder
Allergies	Hearing/Visual Impairment
Asthma	Hepatitis
Autism	Hospital Stays
Blood Disorders	Immune Disorders
Bone/ Muscular Disorders	Kidney/ Liver Conditions
Cancer	Rheumatic/ Scarlet Fever
Congenital Birth Defects	Tuberculosis
Convulsions/Epilepsy	Heart Disease/Murmur
Depression/Anxiety	Diabetes

Other_____
Does your child snore? [ ]YES [ ]NO
Does your child seem rested after sleep? [ ]YES [ ]NO

Have you ever been told your child needs to take antibiotics before dental appointments? [ ]YES [ ]NO
Discuss any serious medical conditions _____
_____
_____
List all medications your child is currently taking _____
_____
List all allergies (drugs, latex, etc): _____
_____
_____

Child's primary Care Physician _____
Address: _____
Phone Number: _____

Section 9: HIPAA

The privacy of your health information is very important to us and our practice follows all HIPAA regulations. Notice of our HIPAA Privacy Practices with complete details have been made available to you and a copy of these HIPAA guidelines can be provided to you at your request.

Please initial below to acknowledge receipt of our HIPAA Privacy Practice Notice.

_____I have carefully read and reviewed a copy of the office's Notice of Privacy Practices.

_____I understand that I am entitled to receive a paper copy of this office's Notice of Privacy Practices available upon request.

Section 10: Complete Registration

Just For Kids Pediatric Dentistry, P.A. is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC, and the ADA.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in strictest of confidence and it is my responsibility to inform the office of any changes in contact information and/or in my child's medical status.

_____ _____
Parent/ Guardian Signature Parent/ Guardian Printed Name

_____
Date

CHILD'S FULL NAME:_____

JUST FOR KIDS
PEDIATRIC DENTISTRY

APPOINTMENT AGREEMENT

Thank you for choosing our office as your child's dental home! We are committed to providing the highest quality care and service to you and your family.

We strive to see all patients on time for their scheduled appointment. There are times when our schedule is delayed in order to accommodate an anxious child or an emergency. Please accept our apologies in advance should this occur during your appointment. We promise to give the same courtesy to your child if they need extra care.

The scheduled appointment is reserved specifically for your child. Any change in this appointment affects many patients. We understand there are times that rescheduling an appointment is unavoidable, however, we ask that you kindly do so by calling ***2 business days in advance*** of any scheduled appointment.

Please read and initial by each appointment agreement below:

_____ Canceling and/or rescheduling appointments without a 2 business day notice are subject to a ***$50 charge per broken appointment.***

_____ We reserve the right to NOT schedule any subsequent appointments after one (1) missed or cancelled appointments without a 2 business day notice.

_____ Multiple same day sibling appointments cancelled or rescheduled without 2 business day notice will result in all future appointments being limited to separate appointments for each child.

_____ If you arrive to your appointment more than 10 minutes late we reserve the right to only complete the services we have time to complete and/ or reschedule your appointment.

Thank you in advance for your understanding of our appointment agreement.

_____ _____

Child's Name Today's Date

_____ _____

Parent/ Guardian Printed Name Parent/ Guardian Signature

JUST FOR KIDS
PEDIATRIC DENTISTRY

FINANCIAL AGREEMENT

PLEASE UNDERSTAND that ***we file insurance as a courtesy to our patients.*** Please realize that your insurance policy is a contract between you, your employer and your insurance company, and not our dental office. We have no control over the terms of your contract, the methods of reimbursement or the determination of benefits. All insurance companies are different and you are responsible for knowing your provisions.

Please read and initial each financial agreement below:

_____ If we receive all of your insurance information by the day of your appointment, we will be happy to file a claim on your behalf. You must be familiar with your insurance benefits as we will collect from you the estimated amount insurance is not expected to pay at the time service is rendered. If we are unable to confirm your child's insurance is active we will collect in full for all services rendered that day.

_____ Please be aware that the parent bringing the child to any or future dental appointments is *legally responsible for payment of all charges.* We cannot send statements to anyone for the estimated out-of-pocket for services being rendered at that appointment.

_____ All estimated patient portions are due in full at the time of service. To help make payments convenient, we accept cash, check, CareCredit and all major credit cards (Visa, MasterCard, Discover, American Express). A returned check fee of $25 will be accessed for any returned check.

_____ Our acceptance of insurance assignments does not absolve you of full responsibility for the treatment rendered. In the unlikelihood that your insurance does not pay for a procedure in full, you will then be responsible for the remaining balance. If payment is not received from the insurance company in 60 days, or if an account balance remains after an insurance payment has been applied, it will be your responsibility to make payment in full within 10 days of the billing date.

MaineCare: Please read and initial each agreement below:

_____ For those patients covered by MaineCare, patients must be eligible for benefits on the date of service, otherwise the account is considered a cash account and payment is due at the time of service. If MaineCare does not make a payment for services rendered, you will be responsible for paying the balance on the account in full within 10 days of the billing date.

_____ If the patient is covered by a primary insurance company that pays the subscriber (ie: Federal Blue Cross Blue Shield), payment will be due at the time of service based on the plans reimbursement rate.

_____ Payment for all services not covered by MaineCare will be due at the time of service.

We recognize that account balances may be incurred. Just For Kids Pediatric Dentistry, P.A. requires that all outstanding balances ***be paid in full within thirty (30) days*** unless other arrangements have been made. Also note that if we have not received payment, or you have not contacted us within thirty (30) days, further action may be taken, in which a 35% collections agency fee may incur.

_____ I agree that balances be applied to my credit card on file. See Credit Card on File Form

Thank you in advance for your understanding of our financial agreement.

_____ _____
Child's Name Today's Date

_____ _____
Parent/ Guardian Printed Name Parent/ Guardian Signature

JUST FOR KIDS
PEDIATRIC DENTISTRY

Credit Card on File Agreement

We can securely maintain your credit card information on file with our merchant services. This information will be securely held until your insurance provider has paid their portion of your bill or if payment has not been received from the insurance provider in 60 days. At that time, any balance, which you owe to our office for services that have already been rendered, will be charged to your credit card and a receipt will be sent to you.

This in no way compromises your ability to dispute a charge or question your insurance company's determination of payment.

Co-pays and coinsurances are still due at the time of service.

I authorize Just For Kids Pediatric Dentistry, P.A. to charge any outstanding balance on my account, including co-payments and coinsurances to the following credit card:

VISA MASTERCARD AMEX DISCOVER

Name on card: _____

Last 4 Digits of Card Number:_____

Expiration date:_____

3 Digit Code (on back of card): _____

Cardholder Signature: _____

Today's Date: _____

If the balance is over $_____ your card will not be ran without prior notification.

I understand that I can cancel this authorization through written notice to Just For Kids Pediatric Dentistry, P.A.

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SHRED AFTER ENTERED INTO SECURE MERCHANT SERVICES

FULL CREDIT CARD #_____