PATIENT REGISTRATION FORM

CHILD FULL NAME	BIRTHDAY	AGE	GENDER	RELATIONSHIP TO GUARDIAN

FAMILY INFORMATION

PARENT / LEGAL GUARDIAN	PARENT / LEGAL GUARDIAN
NAME:	NAME:
SSN:	SSN
ADDRESS:	ADDRESS:
CITY, STATE, ZIP	CITY, STATE, ZIP
CELL PHONE:	CELL PHONE:
HOME PHONE:	HOME PHONE:
DATE OF BIRTH:	DATE OF BIRTH:
EMAIL:	EMAIL:
MARITAL STATUS:	MARITAL STATUS:

PREFERRED METHOD OF CONTACT: (circle all desired) Phone Text Email

DENTAL INSURANCE

PRIMARY INSURANCE	SECONDARY INSURANCE
SUBSCRIBER NAME:	SUBSCRIBER NAME:
NAME OF INSURANCE:	NAME OF INSURANCE:
INSURANCE PHONE #: GROUP #: ID #:	INSURANCE PHONE #: GROUP #: ID #:
EMPLOYER:	EMPLOYER:

How did you hear about us?_____

IKD accepts most dental insurance plans. For your convenience, we send a dental claim to your insurance plan after your child receives treatment. Your insurance company is obligated to pay the claim within 60 days from the date of submission. Claims unpaid after 60 days become your responsibility. You will be sent a statement showing the unpaid claims and/or your financial responsibility after all claims have been processed by your insurance provider. I understand that I am responsible for any charges that are reasonably denied or unpaid by my insurance company.

By signing below, you consent to your child's treatment and your financial obligation to Imagine Kids Dentistry.

Parent/Legal Guardian Signature Date

*Your typed signature is equivalent to your written signature in this packet.

Please email completed forms to office@imaginekidsdentistry.com

MEDICAL AND DENTAL HISTORY FORM

Child's name: _____ Date of Birth:_____ Gender: ☐ Female ☐ Male

What is the main reason you brought your child to us today? _____

Has your child ever had any of the following?	Yes	No	Comments
Heart Murmur			
Congenital heart disease			
Asthma, Cystic Fibrosis, Respiratory Disease			
Diabetes, Thyroid, Glandular, or other Endocrine Disease			
Liver Disease/Hepatitis/Jaundice			
Kidney Disease			
Skin, Bone, Muscle, or Joint Disease			
Seizures/Convulsions/Loss of Consciousness			
Cerebral Palsy or Neurological Disease			
Sexually Transmitted Disease or HIV			
Anemia, Hemophilia, other Blood Disorders			
Sickle Cell Disease or Trait			
Cancer			
Speech disorder			
Hearing disorder			
Sight or eye disorder			
Frequent Headaches			
Mental, Emotional, or Developmental delays			
Autism, ADHD, Genetic Disorder/ Syndrome (please note)			
Frequent infections			
Has your child ever received blood/blood products?			
Has your child ever been hospitalized?			
Has your child ever been seriously ill?			
Has your child ever had any significant injury?			
Has you child ever had surgery?			
Which medicines does your child take at this time?			

Is your child allergic …….			
……. to any medicines?			please list
…….to any foods, environmental pollutants, animal?			please list

Is there any other problem, disease, or medical condition that we should know about in order to care for your child?

☐ No ☐ Yes Please list _____

Who is your child's Primary Physician or Physician's Group?

Name _____ Phone _____

Has your child had any of the following:	Yes	No	Comments
Pain in the teeth			
Swelling of the mouth and face			
Injury to the face or teeth			
A bad dental experience			
Does your water have fluoride			
Does your child thumb suck or other oral habit			
Does your child have any other dental condition			

Which of the following categories best describes your child's learning abilities? ☐ Delayed ☐ Normal ☐ Advanced

How do you think your child will do at the dentist? ☐  ☐  ☐ 

_____ _____ _____

Parent/Guardian Signature Date Reviewed by DDS, DMD

Please submit completed forms to office@imaginekidsdentistry.com

Imagine Kids Dentistry

CONSENT FOR DENTAL TREATMENT

I hereby authorize and request the performance of dental services for my minor child. I understand that at the first appointment (examination, necessary x-rays, cleaning, topical fluoride) the doctor will explain my child's treatment needs and the various behavior management approaches. At this appointment the doctor's staff will review any associated fees. I also realize that any restorative treatment will be accomplished at a later date.

I understand that DENTAL TREATMENT is associated with inherent risks, including, but not limited to, the following:

1. Injury to the nerves as a result of local anesthesia: This would include injuries causing numbness of the lips, the tongue, or other tissues of the mouth or face. This numbness is usually of a temporary nature, but permanent numbness is a possibility. If numbness persists more that 24 hours postoperatively, please call our office.
2. Soreness of the gums: Temporary soreness may result from the placement of a rubber dam, or any restoration that extends below the gumline (e.g. stainless steel crowns). This soreness usually goes away within 48 hours.
3. Sensitivity of teeth: Placement of any dental restoration can result in a tooth that is sensitive to hot and/or cold. If these symptoms persist for more than a few weeks, it may be an indication that further treatment is necessary.
4. Breakage, dislodgement, or bond failure: Due to the fact that teeth are subjected to extreme forces from chewing, grinding, and possible trauma, it is possible that bonded restorations (white fillings) or even amalgam restorations (silver fillings) can be fractured or dislodged, resulting in leakage, recurrent decay, or infection. The dentist has no control over the forces to which the tooth/restoration is subjected.
5. Aesthetics: Although dental materials are constantly improving, it is possible that bonded restorations may wear down, lose their luster, or discolor. The dentist has no control over these factors.
6. For dental extractions:
    - Bleeding, bruising, or swelling: bleeding may persist for several hours. If profuse, please call our office. Some swelling is normal, but if severe, please call our office. Bruising may persist for some time, but generally heals uneventfully.
    - Injury to adjacent teeth or restorations: This is a possibility no matter how carefully the surgery is performed.
    - Infection: Due to the non-sterile nature of the mouth, or perhaps due to an existing infection, post-operative infection is a possibility. Some infections can be very serious. If severe swelling occurs, particularly if associated with fever or malaise, please call our office as soon as possible.
7. For endodontically treated teeth:
    - Pulpotomies: In a small percentage of cases, the patient's body "rejects" the nerve treatment, resulting in a failed pulpotomy and the need for extraction. The dentist has no control over the body's biological response to treatment.
    - Pulpectomies: For teeth requiring a pulpectomy, the long term prognosis is guarded. A significant percentage of pulpectomized primary teeth ("baby teeth") will ultimately need to be extracted. This treatment is generally used when short term retention of a primary tooth is important to long term dental health.
8. IT IS MY RESPONSIBILITY TO SEEK ATTENTION SHOULD ANY COMPLICATIONS OCCUR POST-OPERATIVELY AND I SHALL DILIGENTLY FOLLOW ANY INSTRUCTIONS GIVEN TO ME BY THE DENTIST.
9. For those children receiving nitrous oxide (magic air): Potential side effects include dizziness, nausea, and vomiting. Nitrous oxide should be avoided if your child has just eaten a large meal.

INFORMED CONSENT: I consent for my child(ren) to receive preventative/diagnostic services. I will be given the opportunity to ask questions regarding the proposed treatment and will receive answers to my satisfaction. I will be given alternatives to this treatment, including the option of rendering no treatment. I understand and assume any and all risks associated with the procedures, and I understand that no guarantees will be made regarding the outcome of the treatment. By signing this form, I am freely giving my consent to allow and authorize Dr. Johnson and his associates to render treatment, including any anesthetics or medications.

_____

Print Patient's Name Date

_____

Additional patient's names

_____

Parent/Legal Guardian Signature Printed Name Relationship to patient(s)

Please email completed forms to office@imaginekidsdentistry.com

PATIENT(S) NAME(S)_____

_____

POLICIES AND EXPECTATIONS:

Patients with Insurance: As a courtesy to our patients, we will file your primary and secondary insurance plans for you. Accurate insurance information must be made available in order for us to submit your dental claims. If the insured changes employer, insurance companies, or insurance benefits, it is the insured's responsibility to notify Imagine Kids Dentistry of these updates. Co-payments, deductibles, and payment for non-covered services are due at the time services are rendered. The remaining balance should be paid promptly after receipt of payment from the insurance company. I assign the benefits from my insurance carriers to Imagine Kids Dentistry for dental benefits that my child is entitled to. I authorize Imagine Kids Dentistry to release any information needed to my insurance carrier(s) to determine benefits or benefits payable for related services rendered.

Patients without Insurance: Payment for your child's care is due in full at the time of service. Please inquire in advance if payment arrangements need to be made. For your convenience, we accept credit cards, cash, and checks. We will apply a 10% discount if payment is made in full with cash or a check on the date of service. This discount does not apply to credit card payments.

Collection: I understand that there is no guarantee of reimbursement or payment from my insurance company or other payer. I acknowledge full financial responsibility for, and agree to pay, all charges from Imagine Kids Dentistry for all services rendered not otherwise paid by my insurance or other payer. All charges due are payable upon receipt of the bill. If payment is not made within 60 days after receipt of bill, my account will be considered delinquent and the collection process will begin. If my account is sent to collections, I agree to pay the cost of collection fees, including attorney fees and court costs. I understand that an additional 30% collection fee will be added to my outstanding balance.

Parents: We require that you are present with your children to all of their appointments, regardless of age. Although we are sensitive to the fact that you may have more than one child and that more than one family member may want to participate, we ask that only one adult accompany your child during their treatment and that other children who are not being treated remain in the reception room with a supervising adult. Our goal is to provide the highest quality of care for your child, but to also communicate effectively during treatment. We appreciate your help with this!

Missed/Broken Appointment Policy: Due to the limited space in our schedule and the desire to provide timely service to all our patients, it is very important that you keep your scheduled appointments. We ask that you give us the courtesy of a 24 hr notice so that we may use your appointed time to provide treatment to others in need. If no notice is given, you may be subject to a $25 fee. It is understandable that occasionally you may need to reschedule last minute due to an emergency or illness. If your child is scheduled for sedation, we must have your verbal confirmation by 1 pm the day before the appointment. If confirmation is not received, your child will be removed from the schedule.

Insurance: We follow the guidelines of the American Academy of Pediatric Dentistry regarding frequency of our services. As specialists, we consider these guidelines to be the standard of care. These guidelines are not dictated by dental insurance and it is your responsibility to understand your particular insurance plan's timeline for reimbursement of services. If you have questions, the best source to call is your insurance company.

I understand and agree to the above statements regarding Imagine Kids Dentistry office policies and expectations:

Patient or Parent/Guardian Signature Date

Primary Phone Secondary Phone Email

Billing Address

Please email completed forms to office@imaginekidsdentistry.com

Imagine Kids Dentistry

PERMISSION & FAMILY FORM

Permission

I give permission to the individuals named below to bring my child(ren) to his/her dental appointments at Imagine Kids Dentistry. I further consent that the person(s) named below may make financial and dental/medical decisions for my child(ren) unless I notify the office otherwise.

Authorized Person(s)

Parent/Legal Guardian Signature Date

Parental Separation Policy

We understand that sometimes biological parents are not together anymore and are co-parenting separately. We know this can be complicated, but we respectfully request that we not be involved in any disputes that exist or may arise between the involved parties (Bio Parents, Step-Parents, Guardians, etc). This means that together, you arrange and resolve all aspects of your child's care prior to coming in for appointments. This includes handling insurance, making payment arrangements, and discussing appointment matters prior to scheduling, changing, or canceling appointments.

If there is a situation in which a biological parent has lost rights due to a court order, we must have a copy of legal documentation in your child's chart in order to abide by what is ordered.

By signing below, I agree to comply with the Parental Separation Policy.

Signature Date

Please email completed forms to office@imaginekidsdentistry.com

PRIVACY PRACTICE (HIPAA) CONSENT

Acknowledgement of Notice of Privacy Practice

I have read a copy of the Statement of Privacy Practices (HIPAA Compliance) for IKD. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my child's treatment, payment for services or in the performance of the office's health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to mine and my child's protected health information.

Imagine Kids Dentistry reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If the privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be emailed to me. This consent will remain in effect until terminated by me in writing.

Additional Disclosure Authority

In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my child's protected health information to the persons indicated below. Please note: in situations that two biological parents are no longer together, information can only be kept private from a bio-parent if ordered by a judge. We must have legal documentation on file if information is to be withheld.

Names of Authorized Persons

Authorization & Consent Statements

*please initial beside each statement after reading

_____I do hereby authorize the doctors and their staff at Imagine Kids Dentistry to provide my child with diagnostic and therapeutic procedures, including dental x-rays and photographs, as may be necessary for proper dental care.

_____I do hereby understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment by using praise, explanation, and demonstration of procedures and instruments using variable voice tones. I authorize this Dental Office to administer such medication, including the use of nitrous oxide ("laughing gas"), which is a mild sedative that is inhaled to reduce anxiety and/or the use of a mouth prop.

_____I do hereby authorize payment directly to this Dental Office of the group insurance benefits otherwise payable to me. I understand that I am responsible for all costs of dental treatment and that any estimate given to me is not guaranteed. I authorize the release of any information relative to all claims. The undersigned accepts the fee charged as a lawful debt and promises to pay said fee including the cost of collection, attorney fees and court costs if such be necessary, waiving now and forever the right to claim exemption under the constitution and laws of the State of Colorado or any other state.

_____I acknowledge that I have read the Statement of Privacy Practices in accordance with the Health Insurance Portability & Accountability Act of 1996 (HIPAA), and am free to obtain a copy of it.

_____ _____

Parent/Legal Guardian Signature Date

Please email completed forms to office@imaginekidsdentistry.com