



Patient Information

Patient's Name _____ Name child goes by _____ Sex _____
(First) (Middle) (Last)

Mailing Address _____
(Street) (City) (State) (Zip)

Date of Birth: _____ Age: _____ Weight _____ Patient's Social Security No. _____

Child lives with: Both Parents _____ Mother _____ Father _____ Other _____

Patient's Physician or Pediatrician's Name _____ Family Dentist _____

Names of Siblings:

Child's Name _____ DOB _____ Age _____
Child's Name _____ DOB _____ Age _____

How did you hear about us : _____

E-mail address: _____

Responsible Party Information

Mother

Name _____ Marital Status _____

Social Security No. _____ Birth date _____ Employer _____

Address if different from above _____

Phone: Home _____ Work _____ Cell _____

Father

Name _____ Marital Status _____

Social Security No. _____ Birth date _____ Employer _____

Address if different from above _____

Phone: Home _____ Work _____ Cell _____

Dental Insurance Information

Primary Insured's Name _____ Insured's Soc. Sec. No. _____

Insured's Birth date _____ Primary Insured's Employer _____

Insurance Co. _____ Insurance Co address _____

Subscriber No. _____ Group No. _____ Insurance Co. Phone no. _____

I hereby authorize payment of the dental benefits otherwise payable to me directly to Kool Kids Pediatric Dentistry.

Signed Employee/Subscriber _____



Patient's Name: _____ SS# _____

Medical History

Has your child ever had any of the following medical problems? Please circle below

Seasonal Allergies	Y N	Seizures/Epilepsy	Y N	Thyroid Problems	Y N
Anemia	Y N	Diabetes	Y N	Mental Disorder	Y N
Asthma	Y N	Drug/Alcohol Abuse	Y N	Nervous System Disorder	Y N
Bleeding Disorder	Y N	Fainting	Y N	Rheumatic Fever	Y N
Bronchitis	Y N	Handicap/Disabilities	Y N	Speech Disorder	Y N
Cancer/Chemotherapy	Y N	Hearing Impairment	Y N	Tuberculosis	Y N
Cerebral Palsy	Y N	Hepatitis	Y N	Tumors/Growths	Y N
Congenital Heart Defect	Y N	HIV/AIDS	Y N	ADD/ADHD/ODD	Y N
Heart Murmur	Y N	OCD	Y N	Kidney Problem	Y N
Teeth Grinding	Y N	Autism/Aspergers/PDD	Y N	Thyroid Problems	Y N

If yes to any above please explain _____

Has your child experienced any other physical or mental disorder that is not listed above? Yes No

If yes, please describe: _____

Is your child allergic to any of the following drugs?

Y N Penicillin or Amoxicillin Y N Erythromycin Y N Codeine Y N Dental Anesthetic

Is your child allergic to any other drugs? Yes No If yes, please list _____

Is your child allergic to latex, red dye, eggs or anything else we should be aware of? Yes No

If yes, please list _____

Is your child presently under the care of a physician for any illness? Yes No

If yes, please explain _____

List all drugs or medicines presently being taken: _____

Has your child ever been hospitalized? Yes No

If yes, please give reasons and date(s) _____

May we request the release of your child's medical records if necessary? Yes No



Dental History

Why did you bring your child to see us today? _____

Is this your child's first visit to the dentist? Yes No

Has your child ever had a difficult experience with previous dental treatment? Yes No

If yes, please explain _____

Date of last dental visit _____ Name of Dentist _____

For what service _____

Were any x-rays taken? Yes No

If yes, have x-rays been sent to our office? _____ Date requested _____

How do you expect your child to behave in our office? _____

Do you assist child with brushing? Yes No

Does your child take any type of fluoride supplement? Yes No

Any injuries to mouth, teeth, head? Yes No Date(s) _____

If there is any information that you feel might be of value to us in the treatment of your child, please add it here:

I give my consent for dental treatment and the use of proper and acceptable methods to complete said treatment for my child, (child's full name) _____.

I accept responsibility for payment of services rendered.

Signature (Parent/Guardian) _____

Today's Date _____

Reviewed by Dr. Lepetich _____

HIPAA OMNIBUS RULE
PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original.

MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.

Please **print** name of Patient

Please **sign** for Patient / Guardian of Patient

Legal Representative / Guardian

Relationship of Legal Representative / Guardian

Your comments regarding Acknowledgements or Consents: _____

HOW DO YOU WANT TO BE ADDRESSED WHEN SUMMONED FROM THE RECEPTION AREA:

First Name Only Proper Sir Name Other _____

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR HEALTH INFORMATION:

(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- Cell Phone Confirmation Email Confirmation
 Home Phone Confirmation **Any of the Above**
 Work Phone Confirmation

I AUTHORIZE **INFORMATION ABOUT MY HEALTH** BE CONVEYED VIA:

- Cell Phone Confirmation Email Confirmation
 Home Phone Confirmation **Any of the Above**
 Work Phone Confirmation

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS, FUND RAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

- Phone Message **Any of the Above**
 None of the above (opt out)
 ▪ Email

In signing this HIPAA Patient Acknowledgement Form, you acknowledge and authorize, that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

- It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

Signature of Privacy Officer