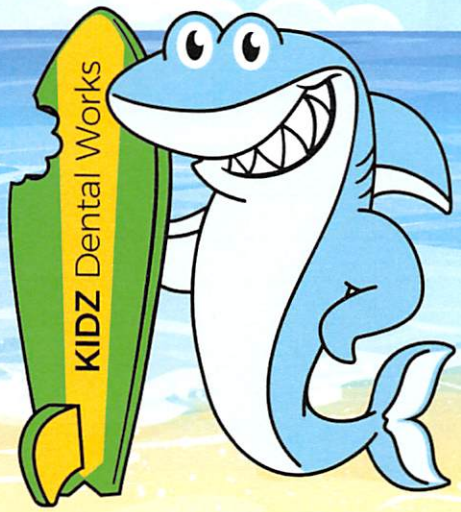

Welcome

We are pleased to welcome you and your family to Kidz Dental Works. Please take a few minutes to fill out this form as completely as you can. If you have question, we'll be happy to help you. We look forward to working with you in maintaining your child's dental health.

Scott Wall, D.D.S.

801-663-7501

1051 W. 200 N. Ste. B Kaysville, UT. 84037

www.KidzDental.net

PATIENT INFORMATION

DATE _____ BIRTHDATE (mm/dd/yyyy) _____

NAME OF MINOR CHILD (last, first, m.i.) _____ ☐ MALE ☐ FEMALE AGE _____

HOME ADDRESS (street/city/state/zip) _____

MAILING ADDRESS (street/city/state/zip) _____

PERSON FINANCIALLY RESPONSIBLE _____

HOME PHONE ( ) _____ WORK PHONE ( ) _____

WHOM MAY WE THANK FOR REFERRING YOU? _____

INSURANCE INFORMATION

FATHER'S/GUARDIAN'S NAME _____

ADDRESS (if different from patient's) _____

_____

HOME PH ( ) _____

WORK PH ( ) _____

CELL PH ( ) _____

E-MAIL _____

EMPLOYER _____

SSN. _____ BIRTHDATE _____

Do you have dental insurance coverage for minor/child? ☐YES ☐NO

PLAN NAME _____ PH ( ) _____

ADDRESS _____

GROUP # _____ POLICY # _____

MOTHER'S/GUARDIAN'S NAME

ADDRESS (if different from patient's) _____

_____

HOME PH ( ) _____

WORK PH ( ) _____

CELL PH ( ) _____

E-MAIL _____

EMPLOYER _____

SSN. _____ BIRTHDATE _____

Do you have dental insurance coverage for minor/child? ☐YES ☐NO

PLAN NAME _____ PH ( ) _____

ADDRESS _____

GROUP # _____ POLICY # _____

DENTAL HISTORY

DATE OF LAST VISIT TO A DENTIST _____

FOR WHAT SERVICE? _____

Has child complained about dental problems? ☐YES ☐NO

Does child brush teeth daily? ☐YES ☐NO

Does child floss daily? ☐YES ☐NO

Is fluoride take in any form? ☐YES ☐NO

Any injuries to mouth, teeth, head? ☐YES ☐NO

Any unhappy dental experiences? ☐YES ☐NO

Any mouth habits: thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? ☐YES ☐NO

MEDICAL HISTORY

MINOR/CHILD'S PHYSICIAN _____

CITY/STATE _____ PHONE ( ) _____

DATE OF LAST PHYSICAL EXAMINATION ..... RESULTS _____

IS MINOR/CHILD UNDER CARE OF A PHYSICIAN NOW?..... ☐YES ☐NO MEDICATIONS _____

RECEIVING ANY MEDICATIONS OF DRUGS? ..... ☐YES ☐NO _____

EVER BEEN HOSPITALIZED?..... ☐YES ☐NO _____

EVER HAD SURGERY?..... ☐YES ☐NO ALLERGIES _____

IS THERE EXCESSIVE BLEEDING? ..... ☐YES ☐NO _____

HAS MINOR/CHILD HAD ANY HISTORY OF, OR DIFFICULTY WITH ANY OF THE FOLLOWING? IF YES, PLEASE CHECK APPROPRIATE BOXES.

☐ AIDS/HIV	☐ CEREBRAL PALSY	☐ EPILEPSY	☐ KIDNEY DISEASE	☐ RHEUMATIC FEVER
☐ ANEMIA	☐ CHICKEN BOX	☐ FAINTING	☐ LIVER DISEASE	☐ SINUS PROBLEMS
☐ ASTHMA	☐ CONVULSIONS	☐ HEARING PROBLEMS	☐ MEASLES	☐ THYROID DISEASE
☐ BLADDER PROBLEMS	☐ DIABETES	☐ HEART PROBLEMS	☐ MONONUCLEOSIS	☐ TUBERCULOSIS
☐ CANCER	☐ DRUG/ALCOHOL ABUSE	☐ HEPATITIS	☐ MUMPS	☐ OTHER

☐ AUTISM, EXPLANATION: _____

EMERGENCY INFO

IN THE EVENT OF ANY EMERGENCY, WHOM SHOULD WE CONTACT?

NAME _____

RELATIONSHIP _____ PHONE ( ) _____

NAME _____

RELATIONSHIP _____ PHONE ( ) _____

AUTHORIZATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

MINOR/CHILD CONSENT

I am the parent, guardian, or personal representative of _____
PLEASE PRINT NAME OF MINOR CHILD

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services of the child named above, including, but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

INSURANCE ASSIGNMENT AND RELEASE

I certify that my dependent(s) is /are covered by insurance with _____
NAME OF INSURANCE COMPANY(IES)

I understand that Kidz Dental Works bills my insurance as a courtesy to me. I am aware that I am responsible for knowing my own insurance coverage. I am fully aware that a $25 charge will be applied to my account for all missed appointments as well as appointments canceled without a 24-hour notice. I am also aware that I am ultimately responsible for any balance owing on the account. In the event that the insurance company does not pay as much as was estimated, I am responsible for the remaining portion. Any portion of the account that has been left unpaid for more than two months will be subject to an eighteen percent (18%) finance charge. The undersigned further agrees to pay any additional collection fees representing up to fifty percent (50%) of the principal balance if the account is referred to a collection agency. The undersigned specifically agrees to pay all attorney fees and court costs in the event legal action is taken to collect on the account. This additional amount is in recognition of the costs associated with the said collections action processing.

_____
SIGNATURE OF PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE DATE

_____
PLEASE PRINT NAME OF PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE RELATIONSHIP TO PATIENT

PRIVACY

I have been given the right to review and receive a copy' of Kidz Dental Works' Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office at the address above and obtain a current copy.

PATIENT NAME _____ SIGNATURE _____

RELATIONSHIP TO PATIENT _____ DATE _____