Just for Kids Pediatric Dentistry, LTD

New patient intake form 2023

Welcome to Just for Kids Pediatric Dentistry. Health issues or certain medications the patient may be taking could have an important interrelationship with the dental care you will receive. The information provided on this form is important to your child's dental health and must be filled out by a parent or legal guardian. Please send completed form to info@justforkidsnaperville.com, fax to 630-579-0850 Thank you!

Patient Information

Today's date: _____

Child's Name_____ **Age**_____ **Date of Birth** _____

Preferred Name _____ Gender ☐ Male ☐ Female ☐ MTF ☐ FTM

Date of Last Dental Appointment_____ Dentist/Practice Name_____

What services did your child have with last Dentist? _____X-Rays? Y/N When? _____

Any siblings to the patient that will be attending our practice? _____

How did you hear about our office? _____

Whom may we thank for referring you to our office? _____

Is there anything you can tell us to help *"Connect"* with your child? (i.e.: favorite movie, princesses, trains, Spiderman, arts/crafts, family dog, etc.)

Parent or Guardian Information

Parents' Names _____ **Marital status** ☐ M ☐ D ☐ Single ☐ Separated ☐ Domestic Partner

_____

With Whom do children reside? _____ Primary language spoken at home? _____

Home address_____ **City**_____ **Zip code** _____

(**alternate**) Home address _____ City_____ Zip code _____

Cell Phone(NAME)(Appt info sent) _____

Cell Phone (ALT/ NAME) _____

Email (Office & appt info sent)_____

Parent or guardian must be at first visit Any follow-up appointments please let front desk know if anyone else is bringing patient**

SECONDARY ADULT CONSENT:**(i.e.: grandma, nannie, caregiver) May accompany your child to future appointments AND give us consent to discuss treatment needs.** *let front desk know prior to visit*

First/Last Name _____ Relationship to child(ren): _____

Home/Cell phone_____ Discuss Treatment Y/N

Parent Signature for Secondary Adult: _____

DENTAL HISTORY

Primary reason for today's visit? _____

Has your child ever been to the dentist? YES_____ NO_____ If Yes, Date of last visit? _____

If yes, how was your child's past dental experience? **Positive/Negative** Comments_____

Is there a family history of cavities? **Y/N** Family history of missing or extra teeth? **Y/N**

How often does the patient brush? _____ Floss? _____ Do you assist? _____

What kind of toothpaste does your child use? ☐ With fluoride ☐ Without fluoride ☐ I am not sure

Primary source of drinking water at home? ☐ City/community supply ☐ Well water ☐ Bottled water ☐ Reverse osmosis filter

Does your child eat three meals a day? **YES/NO** Is your child on a special or restrictive diet? **YES/NO**

If Yes, please describe _____

Does your child have a diet high in sugar and/or starches? **YES/NO** Is your child a "picky eater"? **YES/NO**

How often does your child have any of the following?

Candy and/or other sweets? ☐ Rarely ☐ Occasionally ☐ 1-2 times per day ☐ >2 times per day

Snacks between meals ☐ Rarely ☐ Occasionally ☐ 1-2 times per day ☐ >2 times per day

Soft drinks, sodas, juices, teas, or energy drinks ☐ Rarely ☐ Occasionally ☐ 1-2 times per day ☐ >2 times per day

Please list child's most frequent snacks: _____

Has your child ever had orthodontic treatment (braces)? **YES/NO** **Orthodontist Name/facility** _____

Has your child ever experienced an adverse reaction during, or in conjunction with a medical or dental procedure?

_____YES _____NO Please explain_____

Circle EACH Y or N Has you child had or have any of the following:

Y/N Wear a mouthguard **Y/N** Snoring/Mouth breathing **Y/N** Trouble chewing or swallowing

Y/N Bad Breath **Y/N** Sensitivity to hot/cold **Y/N** Loose teeth or broken fillings

Y/N Bleeding gums **Y/N** Sensitivity when biting **Y/N** Food collection between teeth

Y/N Sensitivity to sweets **Y/N** Fluoride supplements **Y/N** Mouth Sores/Fever Blisters

Y/N Jaw joint problems (clicking, popping, locking or pain?) **Y/N** Bump or trauma to teeth

Y/N Oral habits: ☐ Thumb/finger sucking ☐ pacifier ☐ Nail biting ☐ Other _____

If Yes, for how long & is the habit still present? _____

Is there anything else you would like us to know before treating your child? Please explain:

MEDICAL HISTORY

Name of **child's physician**_____ Phone _____

Child's Immunizations up to date? Y/N

Is your child presently under medical care? **Y/N** Please Explain: _____

Does your child see a Specialist? **Y/N** Please explain: _____

If Yes, name & phone of **Medical Specialist**: _____

Surgeries? Hospitalized? Surgical procedures? Put to sleep/Under general anesthesia? Sedation? **Y/N**

If yes, please list procedures and dates:

ALLERGIES: Is your child allergic to any of the following? Circle any/all that apply:

Antibiotics Gluten Seasonal Acrylics Food Dye Metals Sulfa Anesthetics Latex Dairy Peanuts/tree nuts

OTHER? Please list:

PLEASE CIRCLE Y or N if your child has been diagnosed with or treated for any of the following:

Y/N ADHD/ADD
Y/N Down Syndrome
Y/N Skin Problems
Y/N Acid reflux/GERD
Y/N Seizures/Epilepsy
Y/N Impaired Speech
Y/N Impaired vision
Y/N Impaired Hearing
Y/N Cleft lip/Palate
Y/N Cognitive delays
Y/N Cerebral Palsy (CP)
Y/N Frequent Nose Bleeds
Y/N Bone Issues
Y/N Early onset of puberty/hormonal problems
Y/N Headaches/Dizziness
Y/N Eating disorders
Y/N Blood Transfusion
Y/N Diabetes Type I/II
Y/N Autism Spectrum Disorder
Y/N Asthma/Breathing problems
Y/N Celiac disease
Y/N Anxiety/Depression (circle one)
Y/N Bleeding Disorder
Y/N Cystic Fibrosis
Y/N Cancers/Tumors
Y/N Anemia
Y/N Sickle cell disease/Trait
Y/N Cold Sores/ Herpes

Y/N Infectious diseases: Mono, Hepatitis A-E, Tuberculosis, scarlet fever, Cytomegalovirus (CMV), MRSA, STDs, or HIV/AIDS

Y/N Congenital Heart defect/disease,
Y/N Rheumatic fever or rheumatic heart disease

Y/N Heart murmur (EVER?)

Y/N Neurological, developmental or sensory disorders _____

If yes to ANY, please explain:

Social/Cognitive Development: ☐ at age level ☐ 1-2 years behind ☐ More than 2 years behind

Any issues with physical **growth and/or development**? **YES/NO**

If yes to ANY, please explain:

Any inherited medical conditions, complications before or during birth, prematurity, birth defects or syndromes not previously noted on this form? **YES/NO** If yes, please provide details:_____

_____

Behavioral, emotional, or psychiatric diagnoses/treatment? **YES/NO** If Yes, please list:

PLEASE LIST ALL MEDICATIONS OTC AND/OR PRESCRIBED PATIENT IS CURRENTLY TAKING. (ALLERGY, INHALER, ETC, ALL ARE IMPORTANT)

Medication/Reason/Dosage:

I understand the information given is correct to the best of my knowledge and it is my responsibility to inform JFK of any changes in my child's medical condition or medications.

SIGNATURE_____**DATE**_____

EXAM CONSENT

OFFICE VISITS

All children 3 years of age and above will be brought back to visit with the dentist by themselves. Only for extremely young patients or for patients with special needs will an exception be made to this policy. **A parent or legal guardian MUST be present for all appointments.**

X-Rays & Examination

I understand that my child will be receiving a dental examination from a state licensed and board-certified pediatric dentist. The initial visit is spent conducting a comprehensive examination & depending on your child's age, several x-rays will be taken to determine the presence of cavities between the teeth and the number and location of permanent teeth. **The doctors assess cavity risk and recommend x-rays based on what is best for our patients, regardless of whether your insurance covers this or not.**

Dental Cleaning & Fluoride Treatment

I authorize the providers at Just for Kids Pediatric Dentistry to clean and apply fluoride to my child's teeth. I understand that the application of fluoride is part of the standard of care for children and helps prevents cavities. I understand **recommendations are based on what is standard of care and not based on what your insurance will or will not cover.**

Recall/Routine Re-care system

Recall (6 month) examinations will be conducted in a similar manner. However, if your child maintains zero cavity growth for 12-18 months, we will recommend that diagnostic x-rays be taken on an annual basis rather than at each six-month recall appointment. **IT IS IMPERATIVE THAT ALL CHANGES TO YOUR CHILD'S MEDICAL HISTORY BE BROUGHT TO OUR ATTENTION BEFORE YOUR CHILD IS TAKEN BACK TO SEE THE DENTIST**.

Dental Services

I give my consent to needed dental services, local anesthetic, nitrous oxide analgesia and routine dental treatment with use of proper and acceptable methods to complete treatment. I accept responsibility for payment of services rendered for my child. I understand I will be informed of any treatment other than routine dental treatment before it is performed**. It is the Parent's responsibility to inform the staff during treatment planning if you wish to decline recommended treatment.**

Photography Consent

Digital photos are automatically taken of child(ren) to be used exclusively within their dental record for purposes of ID and dental treatment.
I consent to having occasional "candid" photos and videos taken of my child(ren) and displayed in the office, or social media, such as Instagram and Facebook to promote great dental visits and education. Also, can email to parent upon request:) ☐ **I consent** ☐ **I do not consent**

Financial Policy & Insurance

Payment for initial visit is due at the time of service. ***We are out of network with all insurance companies***. Payment for all visits is due at time of service unless prior arrangements have been made. Insurance is a contract between you and your insurance company; therefore, we ask that you keep up to date with outstanding claims etc**. If your insurance company does not make payments to out-of-network provider, payment is due at the time of services. If you do NOT have dental insurance, payment is due at time of service.** If there are restorative charges, we will require co-pay, plus deductible. Any balance automatically becomes your responsibility and must be paid in full within 14 days after 1st statement is sent**.**

ANY INSURANCE CHANGES, PLEASE LET US KNOW UPON CHECK IN.

*Please ask our team about CARE CREDIT as a payment option. **INITIAL_____**

MISSED APPOINTMENTS: You must provide at least 24 hours' notice if you cancel/miss your schedule appointment. Otherwise, we reserve the right to charge an amount of **$75.00** for a broken appointment. If two appointments are missed during peak, non-school hours, we reserve the right to schedule appointments for your child only during non-peak hours. We also reserve the right to dismiss you from our practice for multiple missed appointments.

INITIAL_____.

MONTHLY BILLING CHARGE:

If any portion of your account remains unpaid, a monthly billing charge of $1.50 per month will be added to the account after 30 days ***with no exceptions***.

OTHER CHARGES (Subject to change without notice) Duplication of Records: $15.00 per child Returned Check: $35.00

Authorization and Release I authorize the dentist to release any information including the diagnosis and the records of any treatment or exam rendered to my child during the periods of such dental care to third party payors, health practitioners or as required by law. **Initial_____**

Parent's Signature & relationship to child: _____ **Date:** _____

JUST FOR KIDS

Insurance Information

Patient Last name:_____ **Date:**_____

PRIMARY DENTAL INSURANCE

Subscriber full name_____ SEX M F

Relationship to Patient_____SS#_____DOB:_____

Employer Name_____ Group #_____

Member ID number_____

Insurance Company Name_____

Address of Ins Co._____

*Need ***ALL*** Information in order to file for your visit. Thank you.

SECONDARY DENTAL COVERAGE (if Applicable)

Subscriber full name_____ SEX M F

Relationship to Patient_____SS#_____DOB:_____

Employer Name_____ Group #_____

Member ID#_____

Insurance Company Name_____

Address of Ins Co._____

Parent Guardian Responsible for patient

PRINT NAME_____

Signature_____ **DATE**_____

JUST FOR KIDS

Pediatric Dentistry, LTD.

Out-of-Network Financial Agreement

We, the staff of Just for Kids Pediatric Dentistry thank you for choosing us as your dental/health provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and building a successful provider-patient relationship with you and your family. We believe your understanding of your financial responsibility is vital to that provider-patient relationship and our goal is not only to inform you of the provisional aspects of this financial policy, but also to keep the lines of communication open regarding them. If at any time, you have any questions or concerns regarding our fees, policies, or responsibilities, please feel free to contact ***Cami Blackshire*** *at* ***(630) 961-0996.***

We believe this level of communication and cooperation will allow us to continue to provide quality service to all our valued patients. Please understand that payment for services is an important part of the provider-patient relationship. To keep our costs reasonable, we require payment at the time of service unless our staff has approved payment arrangements in advance. We make payment as convenient as possible by accepting (Cash, Money Order, MasterCard, Visa and in-state checks). A $35.00 service fee will be charged for all returned checks. **You may authorize us to keep your credit card on file for your convenience knowing that we adhere to the highest level of information security.**

Insurance

Please remember that your insurance policy is a contract between you and your insurance carrier. We have found that insurance companies may try to limit or dictate the services, or level of service a provider can offer to their patients. To avoid this intrusion in the doctor-patient relationship we do not contract with or "restricted" by insurance carriers. This leaves the provider of service and the patient with a direct relationship and the opportunity to make the final decision as to which treatments are most beneficial for the patient. We have found that insurance carriers will request needless and redundant information from a provider of service much more frequently than a patient will. If you have insurance, we will bill your carrier and submit your claim(s) to your insurance provider given we have all the correct and accurate information. Any requests for additional forms from your insurance company will gladly be accommodated for a fee. This includes records, reports, tests, etc. We will provide you with the additional information to submit to your insurance company so there can be no doubt that we are complying with their request. Please retain the original copy for your files. **Please be aware that out-of-network insurance carriers often prohibit assignment of benefits and may try to limit their financial liability with arbitrary limits, exclusions, or reductions such as reasonable and customary or usual and prevailing.** Our fees are well within such ranges and, although we will assist in the filing of an appeal if these limitations are imposed, **the guarantor is responsible for all out-of-network fees**. Unfortunately, we do not negotiate reduced fees with your insurance carrier.

Sign: _____ **Date:** _____

Print Name: _____

JUST FOR KIDS PEDIATRIC DENTISTRY, LTD

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You May Refuse to Sign This Acknowledgment**

I have received a copy of this office's Notice of Privacy Practices.

Print Parent/Guardian Name:_____

Print child(ren)'s Name:_____

Signature:_____

Date:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)