

### Patient Information

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_  
Last First  
 Male  Female  Child  Other \_\_\_\_\_  
 Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_ «BirthDate»  
 Phone (Home): \_\_\_\_\_ Mobile #: \_\_\_\_\_  
 Address: \_\_\_\_\_  
Street  
 \_\_\_\_\_  
City State Zip Code

### Health Information

Date of Last Dental Visit: \_\_\_\_\_ Reason for this visit: \_\_\_\_\_

**Has your child ever had any of the following? Please check those that apply:**

- |  |  |   |   |
|--|--|---|---|
| <input type="checkbox"/> AIDS                | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Nervous Disorders    | <input type="checkbox"/> Codeine Allergy    |
| <input type="checkbox"/> Allergies _____     | <input type="checkbox"/> Excessive Bleeding  | <input type="checkbox"/> Pacemaker            | <input type="checkbox"/> Penicillin Allergy |
| <b>Explain</b> _____                         | <input type="checkbox"/> Head Injuries       | <input type="checkbox"/> Radiation Treatment  |   |
| <input type="checkbox"/> ADD/ADHD            | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Respiratory Problems |   |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Heart Murmur        | <input type="checkbox"/> Rheumatic Fever      |   |
| <input type="checkbox"/> Artificial Joints   | <input type="checkbox"/> Hepatitis           |   |   |
| <input type="checkbox"/> Asperger's Disorder | <input type="checkbox"/> Hay Fever           | <input type="checkbox"/> Sleep Problems       |   |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stomach Problems     | OTHER:                                      |
| <input type="checkbox"/> Autism              | <input type="checkbox"/> Jaundice            | <input type="checkbox"/> Thumb sucking        | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Blood Disease       | <input type="checkbox"/> Kidney Disease      | <input type="checkbox"/> Tuberculosis         |   |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Liver Disease       | <input type="checkbox"/> Tumors               | <input type="checkbox"/> _____              |
| <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Mental Disorders    | <input type="checkbox"/> Venereal Disease     |   |

- Has your child ever had any complications following dental treatment?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Has your child been admitted to a hospital or needed emergency care during the past two years?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Is your child now under the care of a physician?  Yes  No  
If yes, please explain: \_\_\_\_\_
- Name of Physician: \_\_\_\_\_ Phone: \_\_\_\_\_
- Does your child have any health problems that need further clarification?  Yes  No  
If yes, please explain: \_\_\_\_\_

Is your child currently taking any medications? \_\_\_\_\_

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

Signature of patient, parent or guardian \_\_\_\_\_ Date: \_\_\_\_\_

### Referral Information

Whom may we thank for referring you to our practice?  Another patient, friend  Another patient, relative  
 Dental Office  Yellow Pages  Magazine  School  Direct Mailer  Other \_\_\_\_\_  
 Name of person or office referring you to our practice: \_\_\_\_\_

### Responsible Party Information

The following is for:  the patient's parent  the person responsible for payment

Name \_\_\_\_\_

Male  Female  Married  Single  Child  Other \_\_\_\_\_

Social Security #: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Phone (Home): \_\_\_\_\_ (Work): \_\_\_\_\_ Ext: \_\_\_\_\_

E-Mail \_\_\_\_\_ Cell # \_\_\_\_\_

Address: \_\_\_\_\_

Street \_\_\_\_\_ Apartment # \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Parent/Guardian Employment Information

The following is for:  the patient  the person responsible for payment

Employer Name \_\_\_\_\_ Occupation: \_\_\_\_\_

Address: \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

### Insurance Information

#### Primary

Name of Insured: \_\_\_\_\_

Last First MI

Insured's Birth Date: \_\_\_\_\_ ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Insured's Address: \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Insured's Employer Name: \_\_\_\_\_

Address: \_\_\_\_\_

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Patient's relationship to insured:  Self  Spouse  Child  Other \_\_\_\_\_

Insurance Plan Name and Address: \_\_\_\_\_

**Facts about Dental Insurance:** We ask that you realize that we don't work for a dental insurance company. Rather, we work 100% for our patients. We feel that dental insurance can be a great benefit for many patients and want you to know we will do everything in our power to insure you get every benefit allotted in your insurance contract. However, **the treatment we recommend and the fees we charge will always be based on your child's individual needs, not your insurance coverage.**

Your insurance is based on a contract between the employer and the insurance company. We are not part of the contract; and, therefore, not responsible for the terms and/or benefits of your insurance company. Honoring and processing insurance benefits is done as a courtesy to the patient. Dental insurance benefits differ greatly from traditional health insurance. Dental insurance is never a "pay all" solution, but merely an aid. Many plans tell their patients that they will be covered at "100%, 80% or 50%," but do not clearly specify plan fee allowances, annual maximums and limitations. It is more realistic to expect some out of pocket expense to be incurred with most visits to our office. Please ask for plan specifics from our insurance coordinator should you have specific treatment recommendations made by Dr King. Many routine dental services and x-rays are not covered by insurance companies. This does not mean the treatment is not necessary or appropriate; just simply not covered. In some cases, your benefits have specific limitations based on the number or frequency of services your plan will cover. Dr King may ask for x-rays or diagnostic aids more frequently than your annual benefits allow. *We do not provide average dentistry, and we will not recommend treatment or care regulated by your insurance contractual limitations.*

### Consent for Services

I understand that I am responsible for all charges incurred by me or a family member regardless of insurance coverage and **PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.** If my account requires servicing by a collections agency or by an attorney, I understand that I will be liable for all collection fees, attorney fees and applicable court costs, in addition to my outstanding balance. I also request that payment under my dental insurance program be made directly to Daniel A. King, DDS, D.B.A The Children's Dental Zone on any unpaid bills for services. I authorize the release of any dental information necessary to process this and all future claims. The understood business policy is such that the parent or guardian who requests treatment for a child is responsible for all fees for services rendered.

I give Dr King and his office staff permission to use such measures as deemed necessary in their professional judgment to render a diagnosis for my child. This would include, but not be limited to an oral examination, prescribed radiographs (x-rays), prophylaxis, fluoride treatment and other diagnostic aids. I have given an accurate report of my child's physical and mental health history. I have reported any prior allergic/unusual reactions, abnormal bleeding and other conditions related to my child's health and or physical conditions that my child's medical doctor has advised me to report to a dentist.

It is understood that a two business day notice is requested for a change or cancellation of an existing appointment. Changing an appointment without the requested notification may result in a \$50 administrative fee. Multiple cancellations or broken appointments may result in dismissal from The Children's Dental Zone.

**HIPAA Notification:** I have read and understand the Notice of Privacy Practices for The Children's Dental Zone.

I acknowledge that I have read and understand this consent and the meaning of its contents. All questions have been answered in a satisfactory manner and I believe I have sufficient information to give informed consent. I further understand this consent shall remain in effect until terminated in writing by me.

\_\_\_\_\_  
Signature of patient, parent or guardian Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

\_\_\_\_\_  
Signature of guarantor of payment/responsible party Date: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_