Giggles and Grins Pediatric Dentistry

Rebecca Kucera DDS

Tell Us About Your Child

Child's Name: ______________________________________ NickName: __________________________________

Child's Address: ___________________________ City, State, Zip: ____

Date of Birth: _____/_____/_____ Who does your child live with: ____________________________________

Who is accompanying the child to this dental appointment?

Name: __________________________________ Relationship: ____

- Do you have legal custody of this child? ____ Yes ____ No

Legal Guardian

Name:_______________________________________ Name:_______________________________________

Birth date: ___/___/____ Home/Cell #: ___________ Birth date: ___/___/___ Home/Cell #: ______________

Employer:__________________ Work # ____________ Employer:_________________ Work# _____________

__Mother __ Father __Step Parent __Guardian __ Mother __Father__ Step Parent __Guardian

Person Responsible For Account

Name: ____ Home#_______________ Cell#_______________________

Billing Address:______________________ City, State, Zip___________________ Email____________________________

Insurance Information

Primary <u>Dental</u> Insurance____ Phone Number___________________________

Name of Insured__________________________________ Birth date: ____/___/____ Relationship to patient___________________

Insured's ID# OR SS#____ Group Number_____________

Employer____

Secondary <u>Dental</u> Insurance____ Phone Number___________________________

Name of Insured __________________________________ Birth date: ___/___/_____ Relationship to Patient___________________

Insured's ID# ____ Group Number____________

Employer____

How did you hear about us?

__ Internet __ Phonebook __ Pediatrician __ Direct mail __ Insurance Company __ Friend/Family __Website __ Social Media

Referring Person's Name ____

Giggles and Grins Pediatric Dentistry

Rebecca Kucera DDS

(440) 838-1234

PATIENT NAME: ___________________________

Dental History

What brings you here today? ____

When was your child's last dental visit? _________ Who is the previous dentist? ____________________

Does your child brush his/her teeth daily? __ yes __ no Floss? __ yes __ no Fluoride? __ yes __ no

Is your child's water fluoridated? __ yes __ no Is your child taking fluoride supplements? __ yes __ no

Is your child currently breast/bottle feeding? __ yes __ no When was breast/bottle stopped? _________

Does your child suck his/her thumb? __ yes __ no Fingers? __ yes __ no Pacifier? __ yes __ no

Does your child bite his/her lips or fingernails? __ yes __ no

Does your child have speech difficulties? Please explain: ________________________________

Any particular fears or experiences in the dental office? ________________________________

Medical History

Condition	Yes	No
Abnormal Bleeding	___Yes	___No
ADD/ADHD	___Yes	___No
Allergies (Please list_____________)	___Yes	___No
Anemia	___Yes	___No
Asthma	___Yes	___No
Autism/Autism Spectrum	___Yes	___No
Cancer	___Yes	___No
Congenital Heart Defect	___Yes	___No
Convulsions/Epilepsy	___Yes	___No
Diabetes	___Yes	___No
Drug Allergies	___Yes	___No
If yes, please list: ______________________________		
Heart Murmur	___Yes	___No
Hearing Impairment	___Yes	___No
Handicaps/Disabilities	___Yes	___No
Hepatitis	___Yes	___No
Kidney/Liver Problems	___Yes	___No
Latex Allergy	___Yes	___No
Operations/Hospital stays	___Yes	___No
If Yes, please list: ______________________________		
Physical/psychological development delay	___Yes	___No
Rheumatic Fever	___Yes	___ No
Shunts	___Yes	___No
Tuberculosis	___Yes	___No

Please discuss any medical concerns that your child has had or currently has:

____

____

____

Name of Child's Physician: ________________

Physician's Phone # ______________________

List all medications your child is currently taking: ________________________________

____

I understand that the information that I have given is correct to my knowledge, that it will be held in strictest confidence. I will inform this office of any changes in my child's status.

Signature of Parent/Guardian:

____

Date: _____________________________________

I do hereby request and authorize the dental staff to perform necessary dental services for the above named child. I accept full responsibility for full payment of the treatment performed. The parent or Guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

Signature of Parent/Guardian: ______________________________________ Date: ___________________________

Giggles and Grins Pediatric Dentistry

440.838.1234
gigglesandgrinsdds.com

We would like to take this opportunity to thank you for choosing our practice for your child's dental care. We are proud to provide a state of the art facility for the highest quality pediatric dental care.

We understand that you or your child may fell anxious about visiting the dentist. Please know and trust that we are sensitive to your needs, and it is our goal to make you and your child feel comfortable visiting our practice.

Appointment Policies

1. Please contact us by phone or email to schedule an appointment. New patients are always welcome. If you have an emergency, please call the office to arrange to be seen promptly. Should the emergency occur after regular hours, the telephone message will instruct you on how to reach Dr. Kucera.
2. We make every effort to stay on schedule. We ask that you also arrive promptly to your child's scheduled appointment time. Please accept our apologies in advance should we have an injured child emergency that might disrupt our scheduled appointments. Be assured we will extend the same care to your child who has a dental emergency.
3. Please allow 48 hour notice to change your child's dental appointment so that we may give that time to another patient. If your child is ill, please call us ASAP. A fee may be charged for a broken appointment without sufficient notice.

Dental Treatment

1. A Parent or legal guardian must be present in the office during any dental appointment of your child.
2. Please allow our experienced staff to accompany your child through his dental treatment. We are specially trained in helping children cope with their anxiety or negative behavior. Dr. Kucera will ask parents back into the treatment room when she feels necessary.

Finance Plans

1. Payment is due at time of service. For extended treatment, we offer Care Credit which is a dental credit card to allow interest free payments with 6 and 12 month options.

Dental Insurance

1. There are hundreds of dental insurance plans these days. We will contact your insurance company to verify your level of benefits in our specialist practice.
2. We are happy to file your dental claims for you and help you recover the most from your dental benefits
3. We file your insurance as a courtesy to you. Your dental insurance is meant to assist you with your dental expenses. Most do not pay for the services in full. Coverage is based on the plan that your Employer has agreed to allow on your specific dental plan. It is your responsibility to satisfy any account balance in full for services rendered
4. Estimated deductibles and co-pays are due at the time dental services are performed.
5. Please keep us informed of any changes in your insurance at each visit.

Consent to Communication Delivery Methods

______________________________ ________________________ ________

Last Name **First Name** **Date**

Do we have permission to:

Confirm Dental Appointments and send re-care reminders

- Text Message 1 week and 1 day before appointment
  Cell #_____________________________
- Email message 1 week and 1 day before appointment
  Email Address____
- Mail Postcard 3 weeks before appointment
- Phone call 2 days before appointment
  Best phone number___________________________

Reminder: Broken appointments without 24 hour notice (8:00 am Friday for Monday) are subject to a $45.00 fee per patient.

Do we have permission to:

- Send x-rays and/or relevant, dental information to other dental/medical professionals of your choosing

The following people have my permission:

- Accompany my child to dental visits
- Authorize dental treatment on my behalf

____

List any special requests with whom you may or may NOT want information shared

____

____

Signature of Patient or Patient Representative