

CLAYTON KIDS

DENTISTRY



Shraddha Patel Kolappa, DDS

Patient Registration & Health History

Whom May We Thank For Referring You?

General Dentist Friend/One of Our Patients _____ Internet Other _____

Patient Information

Patient Name (Last, First, MI): _____ Today's Date: _____

Birthdate: _____ Age: _____ Male Female Nickname: _____

Child's Home Phone: _____ Child's Home Address: _____

School: _____ Grade: _____ Email Address We May Use: _____

Tell Us About Your Child: _____

Family Information

Name of Person Who is Accompanying Your Child Today: _____ Relationship: _____

Do you have legal custody of this child? Yes No Is your child adopted? Yes No

Parent's Marital Status: Single Married Separated Divorced Widowed

List brothers / sisters with ages: _____

Mother's Information

Name: _____ Birthdate: _____ Check Appropriate: Step-Mother Guardian

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ SSN: _____

Father's Information

Name: _____ Birthdate: _____ Check Appropriate: Step-Father Guardian

Home Phone: _____ Cell Phone: _____ Work Phone: _____

Employer: _____ SSN: _____

Responsible Party & Primary Dental Insurance

Person Responsible for Account: _____ Insurance Co. Name: _____

Insurance Co. Address: _____ Insurance Co Phone: _____

Policy Owner's Name: _____ Policy Owners Birthdate: _____

Relationship to Patient: _____ Group Number: _____ Policy Holder ID: _____

Policy Owner's Employer: _____ Employer's Address: _____

Secondary Dental Insurance

Orthodontic Coverage: Yes No Insurance Co. Name: _____

Insurance Co. Address: _____ Insurance Co Phone: _____

Policy Owner's Name: _____ Policy Owners Birthdate: _____

Relationship to Patient: _____ Group Number: _____ Policy Holder ID: _____

Policy Owner's Employer: _____ Employer's Address: _____

Health History

Is this your child's first dental visit? Yes ___ No ___ Last Visit Date: _____ Your General Dentist: _____

Has your child had an unfavorable experience in a dental office? Yes ___ No ___

What are the main concerns for this dental visit? _____

Have there been any injuries to the face, mouth teeth or chin? _____

Have you been informed that your child has any missing or extra permanent teeth?Yes ___ No ___

Has your child had any pain / tenderness in his / her jaw joint (TMJ / TMD)?Yes ___ No ___

Does your child brush his / her teeth daily?Yes ___ No ___ Floss his / her teeth daily?Yes ___ No ___

Is your home water supply city water or well water? Please check one: Well Water _____ City Water _____

If your child has ever experienced any of the following place a check mark in the box next to the item:

- | | | |
|---|--|--|
| <input type="checkbox"/> Clenching / Grinding Teeth | <input type="checkbox"/> Nail Biting | <input type="checkbox"/> Thumb/Finger/Pacifier Sucking |
| <input type="checkbox"/> Lip Sucking/Biting | <input type="checkbox"/> Nursing Bottle Habits | <input type="checkbox"/> Tongue Thrust |
| <input type="checkbox"/> Mouth Breather | <input type="checkbox"/> Speech Problems | |

COMMENTS: _____

Please describe your child's current physical health (circle one): Good Fair Poor

Is your child currently under the care of a physician?Yes ___ No ___

Child's Physician: _____ Phone Number: _____ Date of last visit: _____

Please list all drugs / things your child is allergic to or write "None": _____

Is your child allergic to: Latex.....Yes ___ No ___ Metals/Nickel..... Yes ___ No ___ Plastics.....Yes ___ No ___

Has your child had an unfavorable reaction to Penicillin, Aspirin, Novocaine or any other medication?

If "Yes", What Type of Reaction? _____

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

Circle Y for Yes and N for No

- | | | |
|--------------------------------------|-------------------------------|-----------------------------|
| Y N Abnormal Bleeding | Y N Asthma - Chronic or Acute | Y N Heart Murmur |
| Y N ADD / ADHD | Y N Cancer | Y N Hemophilia |
| Y N Allergies to any Drugs | Y N Congenital Heart Defect | Y N Hepatitis |
| Y N Allergic to Latex / Metals | Y N Convulsions/Epilepsy | Y N HIV+ / AIDS |
| Y N Allergic to Plastics | Y N Diabetes | Y N Kidney/Liver Problems |
| Y N Any Hospital Stays | Y N Fluoride Treatments | Y N Lupus |
| Y N Any Operations | Y N Handicaps / Disabilities | Y N Rheumatic/Scarlet Fever |
| Y N Artificial bones/Joints/valves | Y N Hearing Impairment | Y N Tuberculosis (TB) |
| Y N Autism | Y N Downs Syndrome | Y N Family History of TB |
| Y N Sensory Disorder (To What?)_____ | | Y N Developmentally Delayed |

Please discuss any medical problems that your child has had: _____

Medications: _____

Financial Responsibility & Authorization Signature

Our office is HIPAA Compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

I understand that the information that I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

Signature of parent or guardian _____ Date: _____

The Parent or Guardian who accompanies the child is responsible for payment. Payment is due at the time service is rendered. As a courtesy we will file your insurance for you; any co-payment or required deductible is due at the time service is rendered. We accept assignment of insurance benefits and all payments made by your insurance carrier will be paid directly to our practice. In the event insurance does not pay for the services rendered, the responsible party will be billed for services in their entirety.

Signature of parent or guardian _____ Date: _____



Privacy Consent

Your protected health information, (i.e., individually identifiable information such as names, dates, phone/fax numbers, email addresses, home addresses, social security numbers and demographic data), may be used in connection with your treatment, payment of your account or health care operations, (i.e., performance reviews, certification, accreditation and licensure).

You have the right to review our notice of privacy policy prior to signing the consent. You have the right to request restrictions on the use of your protected health information.

You may revoke this consent at any time in writing. However, such revocation will not be retro-actively effective and will only apply to actions taken after such time the consent is revoked.

Thank you for your cooperation. Please let us know if you have any questions.

I, the undersigned, do hereby attest that I have afforded the opportunity to review the Clayton Kids Dentistry notice of privacy policy.

Signature of Patient/Parent (if minor): _____

Print Name of Patient/Parent: _____

Date: _____

Patient's Name: _____



PROXY CONSENT TO TREAT MINORS

This form may be used to allow an adult other than a parent to serve as a proxy decision maker for routine dental care and services at Clayton Kids Dentistry.

For some families, it may be convenient to have prior authorization in place that allows routine dental care to be delivered to minors under the care of a proxy decision maker if a parent or legal guardian cannot be present to provide consent. If you would like to appoint a proxy decision maker, please review and complete the following form authorizing dental treatment or services for the care of a minor child.

AUTHORIZATION

I hereby appoint _____
NAME RELATIONSHIP

as a proxy decision maker to consent to and authorize dental care for my child(ren) listed below.

This proxy extends to care deemed necessary by the dentist(s) to treat the conditions present. This consent includes, but is not limited to, routine preventive and restorative procedures. I understand that treatment recommended and rendered is based on what the dentist(s) believe is in the best interest of the patient. This treatment is **NOT** based on insurance coverage, and I understand that failure of an insurer to pay for a procedure does not relieve me the financial obligation for this treatment. (*more than one child may be listed*)

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

Child's Name: _____ DOB: _____

I hereby indemnify and hold harmless Clayton Kids Dentistry from any and all liability for acting in reliance on this authorization. The individual appointment as proxy is permitted to make decisions or consent to the care in my absence. I agree to accept financial responsibility for all care delivered pursuant to this authorization.

Signature of Parent or Legal Guardian

Date

Phone Number



Shraddha P. Kolappa DDS, PA

Financial Agreement

I understand that my insurance policy is a contract between myself and the insurance company, and Clayton Kids Dentistry is not a party to that contract. I am responsible for unpaid balances and non-covered services, which may result in additional fees.

I am responsible for informing the office of all changes to my information and insurance prior to my appointments. Insurance must be in force and verifiable at time of treatment, and if I do not have insurance, I agree to pay in full at the time of the appointment.

Balances over 30 days may be subject to 2% late payment fee per month.

I hereby assign all insurance benefits for services rendered, otherwise payable to me, directly to Clayton Kids Dentistry from Medicaid or my private insurance. I authorize Clayton Kids Dentistry to release medical information to my insurance company, its agents or any third party for use in determining my benefits. If my account enters a delinquent status, I agree to pay all costs of collections including attorney fees and court fees, if applicable. If my account enters court collection status, I accept that I will no longer be a patient of record. I understand that the fee for a returned check is \$35. Clayton Kids Dentistry will maintain patient records for a minimum of seven (7) years following the latest date of service, barring any exceptions where required extended retention may be required.

YOUR SIGNATURE BELOW CERTIFIES YOU HAVE READ< UNDERSTAND AND AGREE TO THE FINANCIAL AND OFFICE POLICY PROVISIONS STATED ABOVE.

Print Name

Sign Name

Date