Dental History

Patient Name: ____________________

Birth Date: ____________________

Has any close family member ever had a serious problem while having surgery under anesthetic? Yes No

Is the patient under the care of a physician? Yes No

If yes, name of physician ____________________ Phone ____________________

Is patient taking medication? Yes No

If yes, please list ____________________

Medical History

Does patient have or use any of the following?

Yes No
☐ ☐ Allergy to Penicillin/Amoxicillin
☐ ☐ Radiation Treatment
☐ ☐ Excessive Bleeding from Cuts or Extractions
☐ ☐ Allergy to Tape or Latex
☐ ☐ Any Heart Ailments
☐ ☐ Angina
☐ ☐ High Blood Pressure
☐ ☐ Heart Murmur / Physician __________
☐ ☐ Congenital Heart Lesions
☐ ☐ Artificial Heart Valve
☐ ☐ Heart Pacemaker
☐ ☐ Stroke
☐ ☐ Heart Surgery / Physician __________
☐ ☐ Anemia or Blood Problems
☐ ☐ Asthma
☐ ☐ Allergy to Other Drugs __________
☐ ☐ Allergy to Anesthetics __________
☐ ☐ Hay Fever or Allergies in General
☐ ☐ Cortisone Medicine
☐ ☐ Autistic
☐ ☐ Cerebral Palsy

Yes No
☐ ☐ Artificial Joint
☐ ☐ Diabetes
☐ ☐ Kidney Problems
☐ ☐ Liver Problems
☐ ☐ Chemical Dependency
☐ ☐ Hepatitis A, B or C
☐ ☐ Blood Transfusion
☐ ☐ Hemophilia
☐ ☐ Malignancies or Leukemia
☐ ☐ Psychiatric Care / Emotional Problems
☐ ☐ Extreme Nervousness / Apprehension
☐ ☐ Physical Handicap
☐ ☐ Mental Retardation
☐ ☐ Mental Illness
☐ ☐ Immune System Disorders (AIDS, HIV, ARC)
☐ ☐ Venereal Disease
☐ ☐ Genital Herpes
☐ ☐ Yellow Fever
☐ ☐ Rheumatic Fever
☐ ☐ Allergy to Red Dye
☐ ☐ Behind on Immunizations

Yes No
☐ ☐ Scarlet Fever
☐ ☐ Sickle Cell Disease
☐ ☐ Emphysema
☐ ☐ Epilepsy or Seizures
☐ ☐ Fainting or Dizzy Spells
☐ ☐ Cough
☐ ☐ Cold Sores
☐ ☐ Allergies or Hives
☐ ☐ Arthritis
☐ ☐ Rheumatism
☐ ☐ Glaucoma
☐ ☐ Pain in Jaw Joints
☐ ☐ Sinus Problems
☐ ☐ Thyroid Disorders
☐ ☐ Eye Disorders
☐ ☐ Tonsillitis
☐ ☐ Ulcer or Colitis
☐ ☐ Tuberculosis (TB)
☐ ☐ Gags Easily
☐ ☐ Any Other Medical Condition
____

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

Patient/Guardian Signature: ____________________ Date: __________ DDS Signature: ____________________ Date: __________

Patient/Guardian Signature: ____________________ Date: __________ DDS Signature: ____________________ Date: __________

Patient/Guardian Signature: ____________________ Date: __________ DDS Signature: ____________________ Date: __________

Patient/Guardian Signature: ____________________ Date: __________ DDS Signature: ____________________ Date: __________

Patient/Guardian Signature: ____________________ Date: __________ DDS Signature: ____________________ Date: __________

Patient/Guardian Signature: ____________________ Date: __________ DDS Signature: ____________________ Date: __________

Patient/Guardian Signature: ____________________ Date: __________ DDS Signature: ____________________ Date: __________

Patient/Guardian Signature: ____________________ Date: __________ DDS Signature: ____________________ Date: __________

Patient/Guardian Signature: ____________________ Date: __________ DDS Signature: ____________________ Date: __________

Patient Information

Wiley M. Elick, D.D.S., Inc.

Patient Name ______________________ Male Female Today's Date ______________
Nickname ______________________ Birth Date ______________
Address ______________________ Child's SS # ______________
City ______________ Zip Code __________ Cell/Primary Phone ______________
E-mail Address ______________________ Alternate Phone ______________

How did you hear about our office?

☐ Friend / Family ☐ Google - Facebook - Website ☐ Phone Book ☐ Other ______________

Please list any additional children seen in our office.

Name(s) ______________________________________

Parent Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Domestic Partner	Parent Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Domestic Partner
Relationship to Patient: ☐Parent ☐Step Parent ☐Guardian ☐Other ________	Relationship to Patient: ☐Parent ☐Step Parent ☐Guardian ☐Other ________
Name ______________	Name ______________
Address ______________	Address ______________
Cell/Primary Phone ______________	Cell/Primary Phone ______________
Alternate Phone ______________	Alternate Phone ______________
Employer ______________	Employer ______________
Business Address ______________	Business Address ______________
Occupation ______________	Occupation ______________
Business Phone ______________ Ext. ______	Business Phone ______________ Ext. ______
Social Security # ______________	Social Security # ______________
CDL # __________ Date of Birth __________	CDL # __________ Date of Birth __________

Person(s) responsible for account ______________________________
Nearest relatives not living with you ______________ Relationship ______________ Phone # ______________
Address ______________________ City ______________ State ______ Zip __________

Primary Insurance	Secondary Insurance
Name (of Member) ______________	Name (of Member) ______________
Social Security # ______________	Social Security # ______________
Date of Birth ______________	Date of Birth ______________
Employed By ______________	Employed By ______________
Occupation ______________	Occupation ______________
Business Address ______________	Business Address ______________
Business Phone ______________	Business Phone ______________
Insurance Co. __________ Group # ________	Insurance Co. __________ Group # ________

Insurance & Financial Information

- All services not covered by dental insurance will be on a cash basis unless arrangements are made prior to dental treatment. Regarding insurance: In order for us to bill your insurance you must present a current insurance card for each company your child is covered under. It is important for you to understand that our professional services are rendered to your family, not the insurance company. If they do not pay in a timely manner (6 weeks) you are directly responsible for all charges. Accounts over 60 days will be charged interest at 1.5% monthly, 18% annually. Estimates for treatment are subject to change.
- I understand that I am responsible for all costs of dental treatment and percentages given by office are only estimates and cannot be guaranteed.
- I authorize the dentist to perform diagnostic procedures and treatment as may be necessary for proper dental care.
- I authorize release of any information concerning my child's health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. I hereby authorize payment of insurance benefits directly to the dentist, otherwise payable to us.
- I attest to the accuracy of the information on this page.

____

Signature **Date**

Wiley M. Elick, D.D.S., Inc.

PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to obtain, use and disclose my protected health information to carry out:

- Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment);
- Obtaining payment from third party payers (e.g. my insurance company);
- The day-to-day healthcare operations of your practice.

I have also been informed of, and given the right to review and secure a copy of your **Notice of Privacy Practices**, which contains a more complete description of the uses and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction.

I understand that I may revoke this consent, in writing at any time. However, any use or disclosure of that occurred prior to the date I revoke this consent in not affected.

Signed this_________day of ______________________,20_____

Printed Patient Name:___________________________________

Relationship to Patient:__________________________________

Signature:____

KIDS DENTAL GROUP

Cancelation Policy:

We strive to provide excellent dental care to you, your family and all of our patients. In order to do so effectively and efficiently, we have developed an appointment system that sets asides ample time for a patient. "No-shows", and late cancelations inconvenience those individuals who need access to dental care in a timely manner. In an effort to reduce the number of such occurrences, we have implemented a Dental Appointment Cancelation Policy and it is effective immediately.

Our policy is as follows:

1. We request you give our office a 24- hour notice in the event you need to reschedule your appointment. Our phone number is (559) 582-3460.

2. If you miss an appointment and do not contact us with at least a **24 hour** prior notice, we will consider this a missed appointment and a **$50.00** no-show fee will be assessed to you, per person, per appointment. This applies to late cancellations and "no-shows."

3. Our office makes reminder calls for appointments. If you are registered for the patient portal, you will receive e-mail reminders as well. ***It is ultimately the patient's responsibility to remember their scheduled appointments.***

This fee will be billed to you directly and is not covered by your insurance. This balance must be paid prior to your next appointment. If you don't have a scheduled appointment, the balance is expected in a timely fashion and if not, will be subject to collections.

We thank you for trusting Kids Dental Group with your dental care.

I have read and understand the Dental Appointment Cancellation Policy and agree to the terms of this policy.

____ ___________________________

Signature Date

____

Printed Name

Cell Phone Consent:

☐ I consent to the dental practice using my cell phone numbers to (choose one or both) ☐ call or ☐ text regarding appointments and to call regarding treatment, insurance, and my account. I understand that I can withdraw my consent at any time. My cell phone numbers are (include area code):

(___)_______________________________ and/or (___)_______________________________

____ ___________________________

Signature Date

____

Printed Name

Coordination of Insurance Benefits

Patient Name ____ Date of Birth_________________________

Every dental insurance company or dental benefits plan has a policy to coordinate the payment of dental care when a patient has coverage with more than one insurance carrier. The following questions will help your dentist to determine your primary insurer.

- Are you covered by more than one insurer or dental plan? ☐ Yes ☐ No
- If yes, list the companies that cover you:

____

____

If you are covered by more than one insurer or dental plan:

- Which coverage is primary (i.e., the plan that covers you other than as a dependent)?

  ____
- If you have two dental benefits plans that are primary (i.e. they both cover you as the primary policyholder), which plan has covered you the longest?

  ____

If the patient is a dependent child covered by the insurance plans of both parents, list the date of birth of each parent.

Insured name: ____________________________________ Date of Birth (month/day): ___________________

Insured name: ____________________________________ Date of Birth (month/day): ___________________

Note: Dental insurers consider the benefits plan of the parent with the earlier birth date in the calendar year to be the primary insurer of children who are covered by the benefits plans of both parents.

- If the patient is a dependent child of parents who are separated or divorced, which parent, if either, has custody of the child? ☐ Mother ☐ Father Other: ________________________________ % ___________

Note: Coverage for the child provided under the dental plan of the parent with custody will be considered primary.

- Has the parent with custody remarried? ☐ yes ☐ no

Primary residency of child or children? Mother __________% Father__________%

If yes, that parent's dental coverage will be primary; then the stepparent's dental coverage comes next. Finally, the dental coverage of the other parent comes last – provided the child is covered by the stepparent's and the other parent's dental plan.

- If the parents of the minor child are divorced, is there a court order that directs which parent has financial responsibility for the child, regardless of who has custody? ☐ Yes ☐ No
  If yes, which parent? ____
- Does the patient have coverage under his or her current employer and through a former employer (e.g., as a laid-off employee or a retired employee)? ☐ Yes ☐ No

Note: The coverage through a patient's current employer is primary to coverage through a former employer.

Signature ____ Date: _________________

KIDS DENTAL GROUP

Wiley M. Elick, D.D.S., Inc.

Parent/Legal Guardian Consent for Dental Treatment

Child's Name	Date of Birth
Child's Name	Date of Birth
Child's Name	Date of Birth
Child's Name	Date of Birth
Parent/Legal Guardian Name	Phone Number

Authorized Caregiver's Information

Caregiver's Name Home Phone Number Cell Phone Number

The above named caregiver shall be authorized to consent for all dental treatment and dental oral anesthesia, for the above named child(ren), which may be required during my absence. I agree to pay for all services provided to my child(ren) that the caregiver authorized.

If circumstances permit and/or if Kids Dental Group needs to contact me, please contact me at the following telephone number: ____

This consent serves as permission for treatment by Kids Dental Group for the above named child(ren). **The authorization shall be effective until:**

____________________: One (1) year from date signed

OR

Until _________________ (list Month, Day, Year)

This authorization will remain in effect until the date stated above unless I revoke this authorization in writing and submit it to Kids Dental Group prior to this date.

Signature

Parent / Legal Guardian (Circle One)	Date
Witness	Date