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

Relationship to Patient: ☐Parent ☐Step Parent ☐Guardian ☐Other _____

Name _____

Address _____

Cell/Primary Phone _____

Alternate Phone _____

Employer _____

Business Address _____

Occupation _____

Business Phone _____ Ext. _____

Social Security # _____

CDL # _____ Date of Birth _____

Parent Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Domestic Partner

Relationship to Patient: ☐Parent ☐Step Parent ☐Guardian ☐Other _____

Name _____

Address _____

Cell/Primary Phone _____

Alternate Phone _____

Employer _____

Business Address _____

Occupation _____

Business Phone _____ Ext. _____

Social Security # _____

CDL # _____ Date of Birth _____

Person(s) responsible for account _____

Nearest relatives not living with you _____ Relationship _____ Phone # _____

Address _____ City _____ State _____ Zip _____

Primary Insurance

Name (of Member) _____

Social Security # _____

Date of Birth _____

Employed By _____

Occupation _____

Business Address _____

Business Phone _____

Insurance Co. _____ Group # _____

Secondary Insurance

Name (of Member) _____

Social Security # _____

Date of Birth _____

Employed By _____

Occupation _____

Business Address _____

Business Phone _____

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**

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		Yes	No		Yes	No	
☐	☐	Allergy to Penicillin/Amoxicillin	☐	☐	Artificial Joint	☐	☐	Scarlet Fever
☐	☐	Radiation Treatment	☐	☐	Diabetes	☐	☐	Sickle Cell Disease
☐	☐	Excessive Bleeding from Cuts or Extractions	☐	☐	Kidney Problems	☐	☐	Emphysema
☐	☐	Allergy to Tape or Latex	☐	☐	Liver Problems	☐	☐	Epilepsy or Seizures
☐	☐	Any Heart Ailments	☐	☐	Chemical Dependency	☐	☐	Fainting or Dizzy Spells
☐	☐	Angina	☐	☐	Hepatitis A, B or C	☐	☐	Cough
☐	☐	High Blood Pressure	☐	☐	Blood Transfusion	☐	☐	Cold Sores
☐	☐	Heart Murmur / Physician _____	☐	☐	Hemophilia	☐	☐	Hives
☐	☐	Congenital Heart Lesions	☐	☐	Malignancies or Leukemia	☐	☐	Arthritis
☐	☐	Artificial Heart Valve	☐	☐	Psychiatric Care / Emotional Problems	☐	☐	Rheumatism
☐	☐	Heart Pacemaker	☐	☐	Extreme Nervousness / Apprehension	☐	☐	Glaucoma
☐	☐	Stroke	☐	☐	Physical Handicap	☐	☐	Pain in Jaw Joints
☐	☐	Heart Surgery / Physician _____	☐	☐	Mental Retardation	☐	☐	Sinus Problems
☐	☐	Anemia or Blood Problems	☐	☐	Mental Illness	☐	☐	Thyroid Disorders
☐	☐	Asthma	☐	☐	Immune System Disorders (AIDS, HIV, ARC)	☐	☐	Eye Disorders
☐	☐	Allergy to Other Drugs _____	☐	☐	Venereal Disease	☐	☐	Tonsillitis
☐	☐	Allergy to Anesthetics _____	☐	☐	Genital Herpes	☐	☐	Ulcer or Colitis
☐	☐	Hay Fever or Allergies in General (Seasonal)	☐	☐	Yellow Fever	☐	☐	Tuberculosis (TB)
☐	☐	Cortisone Medicine	☐	☐	Rheumatic Fever	☐	☐	Gags Easily
☐	☐	Autistic	☐	☐	Allergy to Red Dye	☐	☐	ADHD / ADD
☐	☐	Cerebral Palsy	☐	☐	Behind on Immunizations	☐	☐	Any Other Medical Conditions

Please Explain Any Other Medical Conditions: _____

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: _____

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OVER →

KIDS DENTAL GROUP

Wiley M. Elick, D.D.S., Inc.
833 Greenfield Ave. Ste 105
Hanford, CA 93230
(559)582-3460

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

Parent/Guardian Initial

_____***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 **$75.00** 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.

Parent/Guardian Initial

_____***Cell Phone Consent:*** I consent to the dental practice using my cell phone numbers to (choose one or both) ❑ call or ❑ text regarding appointments, 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 (_____)_____

Parent/Guardian Initial

_____***Billing Statement Delivery:*** I consent to having my billing statements sent by: (Circle all that apply)

Mail Text Email

I have read and understand the above policies and agree to the terms of these policies.

_____ _____
Signature Date

_____ _____
Printed Name Relationship to the patient

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? Parent Name: _____ % _____

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? Parent Name _____% Parent Name_____%

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