Patient First Name: _____ MI: _____ Last Name: _____
Nickname: _____ DOB: _____ M/F: _____

Address: _____
City: _____ State: _____ Zip: _____
Cell Phone: _____ Text Messaging for Confirmation: YES NO

Parent/Guardian Name:_____ Parents SSN: _____

Married Divorced Single Does Your Child Have Dental Insurance? YES NO

Parent/Guardian Employer: _____

Person's Authorized to Bring Your Child: _____

How Did You Hear About Us? _____

Medical History

Is your child currently taking any medications? YES NO If yes please list: _____
_____

Is your child under the care of a physician? YES NO If yes please explain: _____
_____

Has your child been hospitalized in the past? YES NO If yes please explain: _____
_____

CHECK ANY OF THE FOLLOWING FOR WHICH YOUR CHILD HAS BEEN TREATED IN THE PAST 5 YEARS

_____ Allergies	_____ Anemia/Blood Disorder	_____Asthma
_____ Autism	_____ Behavioral Issues	_____ Cancer/Tumors
_____ Developmentally Delayed	_____ Diabetes: Type: _____	_____ Endocrine
_____ Headaches	_____ Hearing Impairment	_____ Heart Defects
_____ Hepatitis	_____ HIV or AIDS	_____ Hydrocephalus
_____ Kidney	_____ Learning Disability	_____ Lung Disease
_____ Liver Disease	_____ Seizure/Fainting/Dizziness	_____ Speech Disorder
_____ Thyroid	_____Vision Impairment	_____ Other

If Other Please List: _____
_____

IS YOUR CHILD UP TO DATE ON VACCINATIONS? _____ If no please explain: _____
_____

CHECK HERE IF YOUR CHILD HAS **NO** MEDICAL CONDITIONS: _____

Parent/Guardian Signature: _____

Clermont Kids Dentistry Financial and Cancellation Policy

Payment is due at the time of service

If you sign consent for another adult to accompany your child or for your child to bring themselves to an appointment, please be sure to send payment with them or contact our office regarding payment prior to your child's appointment.

Dental Insurance

Insurance often does not cover the full cost of the treatment. We will estimate your insurance coverage and bill your insurance for the treatment on your behalf. Any copays or coinsurance are due at time of service and will be collected at your child's appointment. Should your insurance payment differ from the estimate received, the remaining balance is due within 30 days of receiving a statement.

Future appointments will not be scheduled for patients with an outstanding balance on their account until the account is settled. Accounts not settled after 90 days will be referred to a collection agency.

Financial Arrangements

We offer Care Credit as a payment option, to better assist you. To inquire about the details, you may take a brochure or discuss with a front desk staff member. Any questions regarding possible financial arrangements may be directed to our Office Manager.

Broken Appointments

A specific amount of time is reserved especially for you and we strongly encourage all patients to keep their appointments. If you must change your appointment, we require at least **24 hours' notice to avoid a $25.00 broken/cancellation appointment fee.**

I understand that I am responsible for any charges that are reasonably denied by my insurance company. By signing below, I consent to my child's treatment and my financial obligation to Clermont Kids Dentistry

Parent/Guardian Signature: _____ Date: _____

Authorization For Use Or Disclosure Of Patient Photographic and/or Video Images

Authorization: I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed below. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected by HIPAA privacy regulations. Purpose: The photographic/video images, and/or testimonial will be used for: Social Media and/or Advertising Revocability: I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 98 years from date signed. No Treatment Conditions: I understand that the practice cannot condition treatment on whether or not I sign this authorization.

Name of Patient _____ Signature of Guardian/Patient _____

Date _____ Relationship to Patient _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received a copy of the Statement of Privacy Practices for Clermont Kids Dentistry. The Statement of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment for services or in the performance of the office's health care operations. The Statement of Privacy Practices also describes my rights and the responsibilities and duties of this office with respect to my protected health information. The Statement of Privacy Practices is also posted in the facility. Clermont Kids Dentistry reserves the right to change the privacy practices that are described in the Statement of Privacy Practices. If the privacy practices change, I will be offered a copy of the revised Statement of Privacy Practices at the time of my first visit after the revisions become effective. I may also obtain a revised Statement of Privacy Practices by requesting that one be mailed to me.

ADDITIONAL DISCLOSURE AUTHORITY In addition to the allowable disclosures described in the Statement of Privacy Practices, I hereby specifically authorize disclosure of my protected health information to the persons indicated below.

ANY MEMBER OF MY IMMEDIATE FAMILY [ ] YES [ ] NO SPOUSE ONLY [ ]YES [ ] NO OTHER (PLEASE SPECIFY) [ ] YES [ ] NO

Name of Patient _____ Parent/Guardian Signature: _____

Date _____ Relationship to Patient _____

OFFICE USE ONLY

Record of Acknowledgement Not Obtained Provided Prior to Treatment [ ] YES [ ] NO Date Provided: / /Reason For Denial:

[ ] Needed more time to review Statement of Privacy Practices [ ] Wanted to consult with another person before signing

[ ] Unable to sign

[ ] Reason not given [ ] Other (Explain):_____

Parent Guidelines and Practice Terminology

In order to improve the chances of your child having a positive experience in our office, we are selective in our use of words. We try to avoid words that scare the child due to previous experiences. Please support us by NOT USING negative words that are often used for dental care.
These include:

DON'T USE	FRIENDLY VOCABULARY
Drill	Whistle
Drill on Tooth	Clean a Tooth
Needle or Shot	Sleepy Juice
Cavity	Sugar Bug
Yank Tooth	Wiggle a Tooth Out
Tooth Cleaning	Tickle Teeth
Examination	Count Teeth
Explorer	Toothpick
Rubber Dam	Raincoat
Gas	Magic Air

This will help you understand your child's description of the dental experience. Our intention is not to "FOOL" the child. It is to create an experience that is positive. We appreciate your cooperation in helping us build a good dental attitude for your child!

Parents are ALWAYS welcomed to the back office! An introduction and orientation to our Clermont Kids Dentistry team will take place on your first visit. Please use this time to, "Get to know us inside and out!" Our goal is to help each child navigate new or unfamiliar situations on their own. By supporting this guideline you are helping your child develop the self-confidence we all desire our children to have. We suggest the following guidelines to improve a positive outcome.

1. Allow us to prepare your child. A team member will be by their side during their adventure here!
2. Be supportive of the practice's terminology. It really does work!
3. Please be a team player when in treatment area. We love to interact with your child!

These are very important ways that can actively help in the success of your child's visit. We are confident that all will go well and hope the guidelines will help prepare you with confidence for the upcoming appointment.

Parent/Guardian Signature: _____ Date: _____

Print Name_____