# All Kids Pediatric Dentistry

**ALL KIDS PEDIATRICS DENTISTRY**
2630 West Arrowood Rd., Suite C
Charlotte, NC 28273
Phone: (980) 263-2330
Fax: (704) 817-6530

Clear All Forms

## PATIENT INFORMATION

CHILD'S NAME: _____ NICKNAME: _____

FULL ADDRESS: _____

DATE OF BIRTH: _____ AGE: _____ SOCIAL SECURITY #: _____

SCHOOL NAME: _____ SCHOOL GRADE: _____

SIBLINGS' NAMES, AGES & GENDERS: _____

IF PARENTS DO NOT LIVE TOGETHER, WHO DOES THE CHILD LIVE WITH? _____

MOTHER'S NAME: _____ ○ STEPMOTHER ○ GUARDIAN

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

EMPLOYER: _____ EMPLOYER PHONE: _____

FULL ADDRESS: _____

CELL PHONE #: _____ HOME PHONE #: _____

EMAIL: _____

MARITAL STATUS: ○ SINGLE ○ MARRIED ○ SEPARATED ○ WIDOWED ○ DIVORCED

FATHER'S NAME: _____ ○ STEPFATHER ○ GUARDIAN

DATE OF BIRTH: _____ SOCIAL SECURITY #: _____

EMPLOYER: _____ EMPLOYER PHONE: _____

FULL ADDRESS: _____

CELL PHONE #: _____ HOME PHONE #: _____

EMAIL: _____

MARITAL STATUS: ○ SINGLE ○ MARRIED ○ SEPARATED ○ WIDOWED ○ DIVORCED

## METHOD OF PAYMENT

*Fees for dental services are due at time of treatment*

○ Cash or credit/debit card ○ NC Medicaid #: _____

○ Dental insurance, co-payment and deductible (As a courtesy; we will file for insurance benefits for treatment rendered. Any estimated c-payment, deductible or balances not covered by your insurance must be paid in full at treatment visit.

○ Do you have secondary insurance? If so, specify: _____

All account balances which have not been paid within 30 days become the responsibility of the parent/guardian.

HOW DID YOU HEAR ABOUT US? _____

All Kids Pediatric Dentistry

**ALL KIDS PEDIATRICS DENTISTRY**
2630 West Arrowood Rd., Suite C
Charlotte, NC 28273
Phone: (980) 263-2330
Fax: (704) 817-6530

## MEDICAL HISTORY

Name of child's pediatrician/ physician:

_____

Has your child ever been hospitalized since birth? ○ Yes ○ No

If yes, explain: _____

Is your child allergic to any medications/foods? ○ Yes ○ No

If yes, explain: _____

Is your child presently taking any medication? ○ Yes ○ No

If yes, explain: _____

Has your child experienced any of the following medical conditions?

| Y | N | Condition | Y | N | Condition |
|---|---|---|---|---|---|
| ○ | ○ | Asthma | ○ | ○ | Inhaler |
| ○ | ○ | Special Needs | ○ | ○ | Anemia |
| ○ | ○ | Heart Condition | ○ | ○ | Hepatitis |
| ○ | ○ | HIV / AIDS | ○ | ○ | Lung Disease |
| ○ | ○ | Ear Problems | ○ | ○ | Tubes in Ears |
| ○ | ○ | Diabetes | ○ | ○ | Blood Disease |
| ○ | ○ | ADD / ADHD | ○ | ○ | Skin Disorder |
| ○ | ○ | Latex Allergy | ○ | ○ | Tuberculosis |
| ○ | ○ | Liver Problems | ○ | ○ | Cancer / Tumors |
| ○ | ○ | Convulsions / Epilepsy | ○ | ○ | Emotional Disorder |
| ○ | ○ | Abnormal Bleeding | ○ | ○ | Nose / Throat Disorder |
| ○ | ○ | Seasonal Allergies | ○ | ○ | Speech / Vision Problems |
| ○ | ○ | Tonsil / Adenoids Removed | | | |
| ○ | ○ | Stomach / Kidney Problems | | | |
| ○ | ○ | Autism / Asperger's Syndrome | | | |

Other: _____

Please explain any medical condition(s) or concerns that your child has: _____

_____

## DENTAL HISTORY

Is your child on a bottle? ○ Yes ○ No

If no, at what age was it discontinued?: _____

Is your child a thumb/finger sucker or have they ever used a pacifier? ○ Yes ○ No

Age discontinued: _____

Is your primary source of water from a well? ○ Yes ○ No

Has your child ever been seen by a dentist? ○ Yes ○ No

If so, date of last dental care and previous dentist: _____

_____

Has your child had problems with previous dental treatment? ○ Yes ○ No

If yes, explain: _____

Has your child had any type of injury to his/her teeth? ○ Yes ○ No

If yes, explain: _____

Is your child in pain today? ○ Yes ○ No

If yes, explain: _____

Does your child have a dental condition about with you are especially concerned: ○ Yes ○ No

If yes, explain: _____

**AUTHORIZATION & RELEASE**

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I also authorize the dental services my child may need. I also authorize the dentist to release any information including the diagnosis and the records of treatment or examination rendered to my child during the period of such care to third party payers and/or other health practitioners. I request that my insurance company pay directly to the dentist. I understand that my insurance carrier may pay less than the actual bill for services; therefore, I agree to be responsible for payment of all services rendered on my child's behalf.

Signature of Parent/Guardian: _____ Date: _____

ALL KIDS PEDIATRICS DENTISTRY
2630 West Arrowood Rd., Suite C
Charlotte, NC 28273
Phone: (980) 263-2330
Fax: (704) 817-6530

# APPOINTMENT POLICY

1. All Kids Pediatric Dentistry reserves appointments for your child according to their needs and cooperation. Patients may not be seen in the order they arrive due to their treatment needs and the doctor providing their treatment.
2. As a courtesy, our office will attempt to contact you 1-2 days before your appointment for confirmation. However, we do ask that patients assume responsibility for their appointment time.
3. We recommend arriving 15 minutes before your child's appointment to allow for registration and filling out forms. We also recommend providing your insurance information at least 3 days prior to the appointment in order to ensure the exam or treatment can be performed in a timely manner. Failure to arrive early or provide insurance ahead of the appointment may result in your child being seen later than their scheduled appointment time.
4. For **NEW PATIENT** appointments, it is required that the parent or legal guardian bring the patient. Any subsequent appointments may allow for grandparents or other family members to bring the patient.
5. Parents **CAN NOT** drop the patient off and leave the office. Anyone under 18 must have a parent or guardian in the office at all times.
6. In order to establish trust with your child, we may ask parents to wait in the waiting room while their child is being seen. This will help the patient communicate in their way with the dentist and staff.
7. Broken appointments or short term cancellation (within 48 hours) without proper notification can be costly and unfair to patients who need appointments. Please note: Repeated broken appointments and short term cancellations may be subject to dismissal from the practice.
8. Late arrivals cause schedule delays for those patients who arrive promptly at their appointment time. Late arrivals will be worked into the schedule if time allows or re-appointed to another day.
9. During the school months, late afternoon appointments are in high demand. We ask that you help us by understanding when we need to schedule during school hours. We will gladly provide you with a school excuse for your child.
10. If your child is under the age of four, we will schedule your child in the morning. This way the child is fresh and more willing to cooperate. This also allows more one on one, uninterrupted time with the dentist.
11. Treatment that require use of Nitrous Oxide or any other medication will most often be scheduled in the morning and on an empty stomach. This helps prevent the child from becoming ill.

| | |
|---|---|
| Print Name of Parent/Guardian | Patient Name |
| Parent/Guardian Signature | Date |

ALL KIDS PEDIATRICS DENTISTRY
2630 West Arrowood Rd., Suite C
Charlotte, NC 28273
Phone: (980) 263-2330
Fax: (704) 817-6530

# FINANCIAL CONTRACT

Thank you for choosing All Kids Pediatric Dentistry for your child's dental care. As we anticipate a long-term relationship with our patients and their families, keeping current in communication and payment is important.

We at All Kids Pediatric Dentistry are proud to be part of a team whose primary mission is to deliver the finest and most comprehensive dental services available today. We are concerned about your child's dental care and want to ensure that it is performed in a responsible manner.

In order that we may continue to keep our fees as affordable as possible, we must request payment at the time of treatment. We accept cash, Visa, MasterCard, Discover, and American Express. We accept credit card payments over the phone. We also accept Care Credit, which you can apply for in our office, which allows for you to have a convenient monthly payment plan depending upon your credit.

If you have insurance for your child, we will process the claim with your insurance company. We will do our best to give an accurate estimate of your out of pocket expenses. However, these are only estimated out of pocket expenses - we will not have an exact amount of what the insurance company will pay until after they process the claim and provide us, and you, with an "Explanation of Benefits". **All patients are expected to pay for the estimated uncovered portion of your child's care on the day that services are rendered**. We have a traditional "fee for service" structure. Please remember that **you, as the parent, are responsible for any portion not covered by insurance**.

We understand the value of insurance benefits and will assist you in obtaining your maximum benefits. However, we do ask the following: Please read your policy book and/ or talk to your insurance benefits director to be fully aware of any limitations or exclusions. If you have any questions about your insurance coverage, please contact your insurance company. Please keep in mind that your insurance is a contract between you and your insurance company.

## LATE PAYMENTS & BROKEN / MISSED APPOINTMENTS

**Payment for service is due promptly. A billing fee of $15** is applied for each 60 day period a payment is late.

**A fee of $35.00 per child** is applied to your account for each broken appointment with less than 48 hours' notice.

Again, thank you for choosing All Kids Pediatric Dentistry for your child's dental health needs. We look forward to caring for your children for many years to come.

| | |
|---|---|
| Signature of Parent/Guardian | Patient Name |
| Date | |

ALL KIDS PEDIATRICS DENTISTRY
2630 West Arrowood Rd., Suite C
Charlotte, NC 28273
Phone: (980) 263-2330
Fax: (704) 817-6530

# ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Patient Name and Address: _____

_____

I have been informed of the Notice of Privacy Practices for the above named practice.

_____ _____
Signature Date

**For Office Use Only**

We were unable to obtain a written Acknowledgement of Receipt of Notice of Privacy Practices Because:

- An emergency existed and obtaining a signature was not possible at the time.
- The individual refused to sign.
- A copy was mailed with a request for a signature.
- We were unable to communicate with the patient for the following reason:

  _____
- Other: _____

Prepared by: _____

_____ _____
Signature Date

ALL KIDS PEDIATRICS DENTISTRY
2630 West Arrowood Rd., Suite C
Charlotte, NC 28273
Phone: (980) 263-2330
Fax: (704) 817-6530

# CONSENT FOR DENTAL TREATMENT

Patient Name:_____ Today's Date: _____

I, _____, the parent/guardian of the child(ren) listed above, have given Dr. Marcela Mujica and the All Kids Pediatric Dentistry team consent to:

- Take radiographs
- Perform a cleaning and place fluoride
- Provide treatment (restorations, extractions, and appliances)

This consent applies to (check only ONE below):

☐ Today's visit **ONLY**

☐ **Any/All** future visits

Signature:_____

Relationship:_____ Date: _____