



Patient Registration Form

Child 1: Last Name: _____ First: _____ MI: ____ M/F DOB: _____

Child 2: Last Name: _____ First: _____ MI: ____ M/F DOB: _____

Child 3: Last Name: _____ First: _____ MI: ____ M/F DOB: _____

Address: _____ City: _____ State: ____ Zip: _____

Phone: _____

Who Does the Child Live With? _____

Parent/Guardian 1's Information

Parent 1's Name: _____ SS#: _____ DOB: _____

Circle One: Married / Single / Divorced

Address: _____ City: _____ State: ____ Zip: _____

Employed By: _____ Cell #: _____ Work #: _____

Email Address: _____

Parent/Guardian 2's Information

Parent 2's Name: _____ SS#: _____ DOB: _____

Circle One: Married / Single / Divorced

Address: _____ City: _____ State: ____ Zip: _____

Employed By: _____ Cell #: _____ Work #: _____

Email Address: _____

Insurance Information

Insurance Name: _____ ID#: _____

Subscriber: _____ DOB of Subscriber: _____

SS#: _____ Employer: _____

How would you like us to contact you for upcoming appointments?

Circle One: Mom's Email / Mom's Cell / Dad's Email/ Dad's Cell/Home Phone

Would you prefer a call or a text? _____

Have we seen other family members? Circle One: Y / N

How did you hear about Kidzania? _____



Financial Agreement

Please read, initial, and sign stating you have read and understand our terms and conditions.

___ **No show/Late cancel:** We may charge a "Late Cancel" fee if you fail to give 24 hours' notice to cancel or reschedule your appointment. We will charge a "No Show" fee of \$50 for all missed appointments, per occurrence. Should a no show/late cancellation occur among families with multiple patients, we reserve the right to no longer schedule those patients on the same day.

___ **Insurance:** Our relationship is with the patients, not insurance companies. Your insurance is a contract between you and your insurance company. **It is your responsibility to know and understand what services are covered by your insurance company.** We bill your insurance company as a courtesy to you. Although we may estimate what your insurance company will pay, it is the insurance company that makes the final determination of your eligibility and benefits. Please be aware that some (or all) of the services provided may not be covered in full by your insurance company. **You are financially responsible for any services not covered by your insurance.**

___ **Payment:** We require payment for all office visits and procedures be paid at the time/date of service. We accept the following payment options: Cash, Visa, MasterCard, and Discover. All insurance co-pays and deductibles must be paid at the time of service. If problems do arise, we encourage you to contact us promptly for assistance in the management of your account.

___ **Treatment:** **The child's parent or legal guardian must accompany them to their appointments and remain on the premises for the duration of the appointments. For unaccompanied minors, nonemergency treatment will be denied.**

___ **Treatment** for all HMO policies must be paid up front. You will receive a refund via check once the insurance claim is received by our office and insurance payment is made.

___ **Sedation, IV and Hospital Cases:** We require a \$450 deposit for **ALL** sedation, IV Sedation, and hospital cases.

___ **This office does not offer amalgam (silver) fillings.** We only offer composite (white) fillings. This treatment will always be billed out to your insurance as a composite filling. Your insurance may downgrade to the cost of the amalgam filling. Any difference in cost will be the patient's responsibility.

___ **Monthly Statements:** We will send a statement to the billing address you provide notifying you of any balances you may owe. Payment in full is due upon receipt of the statement. If you have any questions about the validity of your balance, it is your responsibility to contact our office.

___ **Past due accounts:** If you fail to make payments as agreed, your account may be referred to a professional collection agency and/or attorney. You will be responsible for all collection costs incurred including collection agency fees, attorney's fees, and court costs, if applicable. If your account is assigned to a collection agency, you will be notified by certified mail that you will no longer be able to receive services from Kidzania Pediatric Dentistry and Orthodontics. Failure to accept this certified letter (or pick up at the post office) serves as a notice of termination until your account has been reinstated to a satisfactory status

___ **Waiver of Confidentiality:** You understand of this account is submitted to a collection agency or attorney, if we have to litigate in court, or if your past due status is reported to a credit reporting agency, the fact that you received treatment at our office may become a matter of public record.

___ **Divorce:** In case of a divorce or separation, the party responsible for the account prior to the divorce or separation remains responsible for the account. In the case of a minor child, after a divorce or separation, the parent authorizing treatment for the child will be the parent responsible for those subsequent charges. If the divorce decree requires the other parent to pay all or part of the treatment costs, it is the authorizing parent's responsibility to collect from the other parent.

___ **Effective Date:** Once you have initialed each line and signed this policy, you agree to all of the terms and conditions contained herein and the policy will be in full force effect

___ **All insurance** benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims.

I have read the Kidzania Pediatric Dentistry Financial Agreement. I understand and agree to this Financial Agreement.

Children's Name(s): _____

Signature of Responsible Party: _____ Date: _____



26785 E. University Dr. STE 200, Aubrey, TX 76227

Office Policies

Accompanying your child

The American Academy of Pediatric Dentistry suggests that all patients aged 3 and over go back without a parent or guardian. We do not mind if you accompany your child to the back, but we may ask you to step to the front if we are doing treatment. We ask that the parents or legal guardians accompany their child(ren) to the appointment.

Finances

Payment for professional services is due at the time dental is provided. Every effort will be made to provide a treatment plan, which fits your schedule and budget. We accept cash, MasterCard, Visa, and Discover.

Appointment Scheduling

Our office will attempt to schedule appointments at your convenience and when the time is available. Preschool children (1-6 years) should be seen in the morning because that is when they are fresher, and we can work more slowly with the child for their comfort. Dental Appointments are an excused absence, and we will provide your child with a school note. Missing school can be kept to a minimum when regular dental care is in place.

Appointment Services

I understand that this appointment and any subsequent appointment may include: **X-Rays and Fluoride**

By reading and signing this form, you agree to adhere to these office policies. If you have any questions or concerns regarding the treatment of your child, our office procedures, finance, or anything else, please feel free to ask.

Parent/Guardian's Signature

Date

HIPAA (Health Insurance Portability Accountability Act)

Notice of Privacy Practices

1. **To provide Treatment** – We will use your health information you provide within our office to give the best dental care possible. This may include sharing your information with referring dentists, physicians, pharmacies, clinical and dental laboratories, or other health care personnel rendering treatment.
2. **To obtain payment** – A written invoice stating dental treatment performed will be sent to your insurance company and provided to you as well. This will include all services rendered in order to collect payment.
3. **Abuse or Neglect** – Government authorities will be notified if we believe a patient is the victim of abuse, domestic violence, or neglect. We will make this disclosure only when we are compelled by our ethical judgment, when we believe we are specifically or authorized by law, or with the patient's agreement.
4. **Friends, Family, or Caregivers** – We will share your information with only those friends, family, or caregivers when informed by you, the patient. This includes medications, treatment needed/performed and payment history. Written permission will be needed before disclosing any information.
5. **Communication and Appointments** – It has always been our courtesy to remind patients of upcoming appointments. This includes post cards and confirmation calls. By signing you consent to receive reminders.

Signature of Parent or Guardian

Date



OFFICE POLICY

If your child is over the age of 5, we ask that you allow them to accompany our staff through the dental experience. We are all highly experienced in helping children overcome anxiety. Separation anxiety is not uncommon in children, so please try not to be concerned if your child exhibits some negative behavior. This is normal and will soon diminish. Studies and experience have shown that most children over the age of 5 react more positively when permitted to experience the dental visit on their own and in an environment designed for children. For the privacy and safety of all patients only **one** parent is allowed to accompany children to the back.

Thank you for your cooperation!

_____ Date _____

(Parent or Guardian Signature)

Pediatric Medical History

Child's legal name: _____ Nickname: _____ Date of birth: ____/____/____
 Birth sex: M F Current gender identity: _____ Pronouns: _____ Race/Ethnicity: _____ Height: ____cm Weight: ____kg
 Name/age and relationship of others living in the household: _____

 Primary physician: _____ Address/phone: _____ Last visit: _____
 Medical specialists: _____ Address/phone: _____ Last visit: _____

- Is your child being treated by a physician at this time? Reason _____ YES NO
 Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? YES NO
 List name, dose, frequency & date started: _____
 Has your child ever been hospitalized, had surgery or a significant injury, or been treated in an emergency department? YES NO
 List date & describe: _____
 Has your child ever had a reaction to or problem with an anesthetic? Describe _____ YES NO
 Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List _____ YES NO
 Is your child allergic to latex or anything else such as metals, acrylic, or dye? List _____ YES NO
 Is your child up to date on immunizations against childhood diseases? YES NO
 Is your child immunized against human papilloma virus (HPV)? YES NO

Please mark YES if your child has a history of the following conditions. For each "YES", provide details in the box at the bottom of this list. Mark NO after each line if none of those conditions applies to your child.

- | | | |
|--|------------------------------|-----------------------------|
| Complications before or during birth, prematurity, birth defects, syndromes, or inherited conditions | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Problems with physical growth or development | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Sinusitis, chronic adenoid/tonsil infections | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Sleep apnea/snoring, mouth breathing, or excessive gagging | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Irregular heart beat or high blood pressure | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Asthma, reactive airway disease, wheezing, or breathing problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cystic fibrosis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Frequent colds or coughs, or pneumonia | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Frequent exposure to tobacco smoke | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Jaundice, hepatitis, or liver problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Bladder or kidney problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Fine/gross motor deficits, arthritis, limited use of arms or legs, muscle/bone/joint problems, or scoliosis | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Rash/hives, eczema or skin problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Impaired vision, visual processing, hearing, or speech | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Developmental disorders, learning problems/delays, or intellectual disability | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cerebral palsy, brain injury, epilepsy, or convulsions/seizures | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Autism/autism spectrum disorder | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Recurrent or frequent headaches/migraines, fainting, or dizziness | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Attention deficit/hyperactivity disorder (ADD/ADHD) | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Behavioral, emotional, communication, or psychiatric problems/treatment | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Abuse (physical, psychological, emotional, or sexual) or neglect | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Diabetes, hyperglycemia, or hypoglycemia | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Precocious puberty or hormonal problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Thyroid or pituitary problems | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Anemia, sickle cell disease/trait, or blood disorder | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Hemophilia, bruising easily, or excessive bleeding | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Transfusions or receiving blood products | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant | <input type="checkbox"/> YES | <input type="checkbox"/> NO |
| Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS | <input type="checkbox"/> YES | <input type="checkbox"/> NO |

PROVIDE DETAILS HERE: _____

- Is there any other significant medical history pertaining to this child or his/her family that the dentist should be told? YES NO
 If YES, describe _____

What is your primary concern about your child's oral health? _____

How would you describe:

- your child's oral health? Excellent Good Fair Poor
your oral health? Excellent Good Fair Poor
the oral health of your other children? Excellent Good Fair Poor Not applicable

Is there a family history of cavities? YES NO If yes, indicate all that apply: Mother Father Brother Sister

Does your child have a history of any of the following? For each YES response, please describe:

- Inherited dental characteristics YES NO _____
Mouth sores or fever blisters YES NO _____
Bad breath YES NO _____
Bleeding gums YES NO _____
Cavities/decayed teeth YES NO _____
Toothache YES NO _____
Injury to teeth, mouth or jaws YES NO _____
Clinching/grinding his/her teeth YES NO _____
Jaw joint problems (popping, etc.) YES NO _____
Excessive gagging YES NO _____
Sucking habit after one year of age YES NO If yes, which: Finger Thumb Pacifier Other For how long? _____

How often does your child brush his/her teeth? _____ times per _____ Does someone help your child brush? YES NO

How often does your child floss his/her teeth? Never Occasionally Daily Does someone help your child floss? YES NO

What type of toothbrush does your child use? Hard Medium Soft Unsure

What toothpaste does your child use? _____

What is the source of your drinking water at home? City/community supply Private well Bottled water

Do you use a water filter at home? YES NO If YES, type of filtering system: _____

Please check all sources of fluoride your child receives:

- Drinking water Toothpaste Over-the-counter rinse Prescription rinse/gel Prescription drops/tablets/vitamins
 Fluoride treatment in the dental office Fluoride varnish by pediatrician/other practitioner Other: _____

Does your child regularly eat 3 meals each day? YES NO

Is your child on a special or restricted diet? YES NO If YES, describe: _____

Is your child a 'picky eater'? YES NO If YES, describe: _____

Does your child have a diet high in sugars or starches? YES NO If YES, describe: _____

Do you have any concerns regarding your child's weight? YES NO If YES, describe: _____

How frequently does your child have the following?

- Candy or other sweets Rarely 1-2 times/day 3 or more times/day Product _____
Chewing gum Rarely 1-2 times/day 3 or more times/day Type _____
Snacks between meals Rarely 1-2 times/day 3 or more times/day Usual snack _____
Soft drinks* Rarely 1-2 times/day 3 or more times/day Product _____

(* such as juice, fruit-flavored drinks, sodas, colas, carbonated beverages, sweetened beverages, sports drinks, or energy drinks)

Please note other significant dietary habits: _____

Does your child participate in any sports or similar activities? YES NO If YES, list: _____

Does your child wear a mouthguard during these activities? YES NO If YES, type: _____

Has your child been examined or treated by another dentist? YES NO

If YES: Date of first visit: _____ Date of last visit: _____ Reason for last visit: _____

Were x-rays taken of the teeth or jaws? YES NO Date of most recent dental x-rays: _____

Has your child ever had orthodontic treatment (braces, spacers, or other appliances)? YES NO If YES, when? _____

Has your child ever had a difficult dental appointment? YES NO If YES, describe: _____

How do you expect your child will respond to dental treatment? Very well Fairly well Somewhat poorly Very poorly

Is there anything else we should know before treating your child? YES NO

If yes, describe: _____

Signature of parent/guardian _____

Relationship to child _____

Date _____

Signature of staff member reviewing history _____

MEDICAL/DENTAL HISTORY UPDATE

Is your child being treated by a physician at this time? Reason _____ YES NO

Is your child taking any medication (prescription or over the counter), vitamins, or dietary supplements? YES NO

List name, dose, frequency & date started: _____

Has your child had any illness, surgery, injury, allergic reaction, or medical emergency in the past year? YES NO

Describe: _____

Has your child ever had a reaction to or problem with an anesthetic? Describe: _____ YES NO

Has your child ever had a reaction or allergy to an antibiotic, sedative, or other medication? List: _____ YES NO

Is your child allergic to latex or anything else such as metals, acrylic, or dye? List _____ YES NO

Have there recently been any significant changes/disruptions to your child's family, home, or school routines? YES NO

Describe: _____

What is your primary concern regarding your child's oral health? _____

Has your child had any tooth pain or injury to the mouth/teeth/jaws since last visiting our office? YES NO

Describe: _____

Has your child's diet changed significantly since his/her last dental visit? Describe: _____ YES NO

Has your child been treated by another dentist/dental professional since last visiting our office? Reason: _____ YES NO

Is there any other change in the child's medical, dental, or family history that the dentist should be told? YES NO

Describe: _____

Signature of parent/guardian _____

Relationship to child _____

Date _____

Signature of staff member reviewing history _____

SUPPLEMENTAL HISTORY QUESTIONS FOR AN INFANT/TODDLER

Was your child born prematurely? YES NO If YES, what week? _____

What was your child's birth weight? _____

How long was your child breast-fed? N/A less than 6 months 6-11 months 12-17 months 18-23 months 2 years or more

How long was your child bottle-fed? N/A less than 6 months 6-11 months 12-17 months 18-23 months 2 years or more

Do/did you feed your child infant formula? YES NO If YES, what type? (check one): Ready to use Powdered Liquid concentrate

Does/did your child sleep with a bottle? YES NO If YES, content of bottle? _____

Does/did your child use a no-spill training cup (sippy cup)? YES NO

Child's age (in months) when first tooth appeared in mouth _____

Has your child experienced any teething problems? YES NO

When did you begin brushing his/her teeth? N/A before age 6 months 6-11 months 12-17 months 18-23 months 2 years or more

When did you begin using toothpaste? N/A before age 6 months 6-11 months 12-17 months 18-23 months 2 years or more

Who is your child's primary care taker during the day? _____ during the evening? _____

Name/age of siblings at home: _____

Signature of parent/guardian Relationship to child Date Signature of staff member reviewing history

SUPPLEMENTAL HISTORY QUESTIONS FOR AN ADOLESCENT PATIENT (to be completed by the patient)

For each YES response, please describe: _____

Do you have any concerns about your mouth, teeth, or oral health? NO YES _____

Have you recently experienced any dental/oral pain? NO YES _____

Do you have any concerns with the appearance of your teeth or smile? NO YES _____

Do you bleach your teeth? NO YES _____

Have there been any recent changes in your dietary habits? NO YES _____

Are you taking any dietary or herbal supplements? NO YES _____

Do you participate in sports or high speed activities (for example skiing, four-wheeling, motorcycling)? NO YES _____

We recognize that patients may engage in certain behaviors/activities that can have significant consequences on their oral health and/or general health. In addition, medicines that we use to treat oral conditions may interact with drugs (prescription, over-the-counter, or recreational) and other substances a patient might be using. Therefore, we encourage our adolescent patients to answer all of the following questions truthfully. If you prefer not to answer an item, we hope you will discuss any concerns confidentially with your dentist.

Do you have any history of:

Oral habits (chewing fingernails, clenching/grinding teeth, etc.) NO YES PREFER NOT TO ANSWER

Tobacco use (cigarette, pipe, cigar, bidi, snuff, spit, chew, etc.) NO YES PREFER NOT TO ANSWER

Electronic cigarette (e-cig) use NO YES PREFER NOT TO ANSWER

Eating disorder (anorexia, bulimia, etc.) NO YES PREFER NOT TO ANSWER

Oral piercings/jewelry (including grill) NO YES PREFER NOT TO ANSWER

Alcohol or recreational drug use/prescription abuse NO YES PREFER NOT TO ANSWER

Inhalant use/abuse (such as huffing) NO YES PREFER NOT TO ANSWER

Sexual activity (including oral sex) NO YES PREFER NOT TO ANSWER

Abuse (physical, sexual, verbal, mental) NO YES PREFER NOT TO ANSWER

Anxiety, depression, or feeling helpless/hopeless NO YES PREFER NOT TO ANSWER

Females: Are you pregnant or possibly pregnant? NO YES

Is there anything you would like to discuss confidentially with your dentist? NO YES

Would you like to discuss a referral to a family dentist or general dentist because of your age? NO YES

Signature of patient Date Signature of staff member reviewing history