KIDZANIA
Pediatric Dentistry and Orthodontics

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? _____

KIDZANIA
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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: _____

KIDZ-ANIA
Pediatric Dentistry and Orthodontics

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

KIDZMANIA
Pediatric Dentistry

OFFICE POLICY

If your child is over the age of 3, 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 3 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 ..... ❑ YES ❑ NO
Problems with physical growth or development ..... ❑ YES ❑ NO

Sinusitis, chronic adenoid/tonsil infections ..... ❑ YES ❑ NO
Sleep apnea/snoring, mouth breathing, or excessive gagging ..... ❑ YES ❑ NO

Congenital heart defect/disease, heart murmur, rheumatic fever, or rheumatic heart disease ..... ❑ YES ❑ NO
Irregular heart beat or high blood pressure ..... ❑ YES ❑ NO

Asthma, reactive airway disease, wheezing, or breathing problems ..... ❑ YES ❑ NO
Cystic fibrosis ..... ❑ YES ❑ NO
Frequent colds or coughs, or pneumonia ..... ❑ YES ❑ NO
Frequent exposure to tobacco smoke ..... ❑ YES ❑ NO

Jaundice, hepatitis, or liver problems ..... ❑ YES ❑ NO
Gastroesophageal/acid reflux disease (GERD), stomach ulcer, or intestinal problems ..... ❑ YES ❑ NO
Lactose intolerance, food allergies, nutritional deficiencies, or dietary restrictions ..... ❑ YES ❑ NO
Prolonged diarrhea, unintentional weight loss, concerns with weight, or eating disorder ..... ❑ YES ❑ NO

Bladder or kidney problems ..... ❑ YES ❑ NO
Fine/gross motor deficits, arthritis, limited use of arms or legs, muscle/bone/joint problems, or scoliosis ..... ❑ YES ❑ NO
Rash/hives, eczema or skin problems ..... ❑ YES ❑ NO

Impaired vision, visual processing, hearing, or speech ..... ❑ YES ❑ NO
Developmental disorders, learning problems/delays, or intellectual disability ..... ❑ YES ❑ NO
Cerebral palsy, brain injury, epilepsy, or convulsions/seizures ..... ❑ YES ❑ NO
Autism/autism spectrum disorder ..... ❑ YES ❑ NO
Recurrent or frequent headaches/migraines, fainting, or dizziness ..... ❑ YES ❑ NO
Hydrocephaly or placement of a shunt (ventriculoperitoneal, ventriculoatrial, ventriculovenous) ..... ❑ YES ❑ NO

Attention deficit/hyperactivity disorder (ADD/ADHD) ..... ❑ YES ❑ NO
Behavioral, emotional, communication, or psychiatric problems/treatment ..... ❑ YES ❑ NO
Abuse (physical, psychological, emotional, or sexual) or neglect ..... ❑ YES ❑ NO

Diabetes, hyperglycemia, or hypoglycemia ..... ❑ YES ❑ NO
Precocious puberty or hormonal problems ..... ❑ YES ❑ NO
Thyroid or pituitary problems ..... ❑ YES ❑ NO

Anemia, sickle cell disease/trait, or blood disorder ..... ❑ YES ❑ NO
Hemophilia, bruising easily, or excessive bleeding ..... ❑ YES ❑ NO
Transfusions or receiving blood products ..... ❑ YES ❑ NO
Cancer, tumor, other malignancy, chemotherapy, radiation therapy, or bone marrow or organ transplant ..... ❑ YES ❑ NO

Mononucleosis, tuberculosis (TB), scarlet fever, cytomegalovirus (CMV), methicillin resistant staphylococcus aureus (MRSA), sexually transmitted disease (STD), or human immunodeficiency virus (HIV)/AIDS ..... ❑ YES ❑ 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