760.745.7070
info@kidzcaredental.com
www.kidzcaredental.com
625 W. Citracado Parkway, Ste 208
Escondido, CA 92025

New Patient Dental & Medical History Form

We are pleased to welcome you to our practice. Please complete this form. The following information is necessary to enable us to provide your child with the best dental care possible. All information disclosed is confidential and shall only be used for dental and medical purposes.

Patient's Name: _____ _____ _____
Last First MI Preferred Name

Address: _____
Street Apt # City State Zip

Gender: ☐ Female ☐Male **Age**: _____ **Date of Birth**: _____ **SSN**: _____

Father's Information:

Name: _____
Last First

Phone: _____ _____
Home Mobile

Date of Birth: _____

E-Mail: _____

Employer: _____

Occupation: _____

Mother's Information:

Name: _____
Last First

Phone: _____ _____
Home Mobile

Date of Birth: _____

E-Mail: _____

Employer: _____

Occupation: _____

Parents' Marital Status: ☐Single ☐Married ☐Widowed ☐Divorced ☐Separated

Who has legal custody of the child? (if applicable): ☐Mother ☐Father ☐Joint ☐Other ☐N/A

Is patient a foster child? ☐Yes ☐No *If yes, please provide court documents.*

Please list other children in the family:

Full Name	Relationship	Age	Date of Birth

Contact person
(*in case of emergency*): _____ _____ _____
Name Relationship Phone No.

Whom may we thank for referring you to our practice? (*please specify*)

☐ Dental Office: _____ ☐ Internet: _____

☐ Physician: _____ ☐ Fair/Event: _____

☐ School/Day Care: _____ ☐ Direct Mail _____

☐ Insurance: _____ ☐ Sign in building _____

☐ Family/Friend: _____ ☐ Other (specify): _____

DENTAL INSURANCE INFORMATION

Does patient carry dental insurance? ☐Yes ☐No

Primary Insurance Information (Who is the primary subscriber on your dental insurance?)

Name: _____ _____ _____ _____
Last First MI Relationship to Patient

SSN: _____ **Driver's License #:** _____ **Date of Birth:** _____

Employer: _____ **Address:** _____

Dental Insurance: _____ **ID No.:** _____ **Group No.:** _____

Medical Insurance: _____ **ID No.:** _____ **Group No.:** _____

Secondary Insurance Information (Complete only if patient is covered by another insurance company)

Name: _____ _____ _____ _____
Last First MI Relationship to Patient

SSN: _____ **Driver's License #:** _____ **Date of Birth:** _____

Employer: _____ **Address:** _____

Dental Insurance: _____ **ID No.:** _____ **Group No.:** _____

FINANCIAL RESPONSIBILITY FOR SERVICES

I hereby assign directly to Kidz Care Dental Group all dental benefits, if any, otherwise payable to me for services rendered to my child. I authorize to affix my name and validate "signature on file" to all claims and documents related to any health benefits and release any information necessary to bill my child's insurance carrier. I understand that I am financially responsible for any charges not covered by my child's insurance and that my portion is due and payable at the time services are rendered unless other arrangements have been made. I understand that any account balance over 30 days will be charged 1.5% interest per month, and/or late fees and service charges where applicable. I agree to pay all costs of collection including but not limited to court costs, commissions and costs of collection agency and reasonable attorney fees.

Signature of responsible party: _____ **SSN:** _____

Name of Responsible Party: _____ **Date of Birth:** _____

Relation to Patient: _____

Date: _____

MEDICAL HISTORY

Child's Physician: _____ **Phone No.:**_____

Address: _____

Date of Last Physical Exam: _____

	Yes	No	
Is patient in good health?	☐	☐	
Has patient ever had health problems/been hospitalized?	☐	☐	Please give reason/date: _____
Is patient currently taking medication?	☐	☐	If yes, specify: _____
Have you ever been told that patient needs antibiotics before dental treatment?	☐	☐	
Does patient have any food allergies?	☐	☐	If yes, please specify: _____
Does patient have any allergies to medication?	☐	☐	If yes, please specify: _____
Is patient allergic to latex?	☐	☐	
Does patient have any other allergies?	☐	☐	If yes, please specify: _____

Does patient have or has patient ever had the following conditions?

	Yes	No
Arthritis	☐	☐
Asthma	☐	☐
Diabetes	☐	☐
GI Disorder	☐	☐
Heart Disease	☐	☐
Kidney Disease	☐	☐
Rheumatic Fever	☐	☐
ADHD	☐	☐
Anxiety/Nervousness	☐	☐
Autism	☐	☐
Emotional Disability	☐	☐
Learning Disability	☐	☐
Behavior Issues	☐	☐
Psychiatric Disorder	☐	☐
Hepatitis	☐	☐
HIV Infection	☐	☐
Tuberculosis	☐	☐
Anemia	☐	☐
Bleeding (Prolonged)	☐	☐
Hemophilia	☐	☐

	Yes	No
Brain Injury	☐	☐
Cerebral Palsy	☐	☐
Cleft Lip/Palate	☐	☐
Developmental Delay	☐	☐
Eating Problems	☐	☐
Growth Problems	☐	☐
Seizures	☐	☐
Speech Problems	☐	☐
Hearing Loss	☐	☐
Neuromuscular Defect	☐	☐
Orthopedic Problems	☐	☐
Cancer	☐	☐
Leukemia	☐	☐
Fainting/Headaches	☐	☐
Gag Reflex	☐	☐
Sleep Apnea	☐	☐
Sleep Problems	☐	☐
Snoring	☐	☐
Other (please specify):	_____	

DENTAL HISTORY

Is this the patient's first visit to the dentist? ☐ Yes ☐ No If no, when was the last visit? _____

Name of previous dentist: _____ Phone No.: _____

Please describe patient's dental problem(s): _____

_____

Please check any of the following that may describe the patient's attitude towards dentistry:

☐ Cooperative ☐Friendly ☐Anxious ☐Shy ☐Uncooperative

Does the patient have any of the following habits?

	Yes	No
Nursing bottle	☐	☐
Nail biting	☐	☐
Thumb/finger sucking	☐	☐
Pacifier sucking	☐	☐
Teeth grinding	☐	☐
Cheek/lip biting	☐	☐
Jaw clenching	☐	☐
Mouth breathing	☐	☐

Other (*Please specify*): _____

Does the patient have problems with any of the following?

	Yes	No
Cavities	☐	☐
Nail biting	☐	☐
Thumb/finger sucking	☐	☐
Pacifier sucking	☐	☐
Teeth grinding	☐	☐
Cheek/lip biting	☐	☐
Jaw clenching	☐	☐

Other: _____

	Yes	No	
Has the patient had any unhappy dental experience?	☐	☐	
Has the patient had local anesthesia (Novocain)?	☐	☐	If yes, were there any problems? _____
Does the patient brush his/her teeth?	☐	☐	
Do you assist in brushing the patient's teeth?	☐	☐	
Does the patient use dental floss?	☐	☐	
Does the patient use fluoride in any form?	☐	☐	*Please specify*: ☐Tablets ☐Drops ☐Water ☐Gel/Paste ☐Rinse
Does the patient have sugar snacks? (e.g. raisins, fruit rollups, candy, etc.)	☐	☐	*If yes, how often?* _____times a day _____times a week
Does the patient drink soda and/or juice?	☐	☐	*If yes, how often?* _____times a day _____times a week

Is there anything else we should know regarding the patient's dental health?

_____

_____

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CONSENT FOR SERVICES

I am the parent, guardian, or authorized caregiver for the patient and there are no court orders now in effect that limits me from signing this consent. I understand that the information I have given is correct to the best of my knowledge, that it will be held with confidentiality. It is my responsibility to inform the dental staff of any changes in my child's health status. I hereby authorize Dr. Tahir Paul and his associates to perform and necessary dental services including but not limited to comprehensive examination, taking dental x-rays, photographs or any diagnostic aids deemed appropriate to make a thorough diagnosis of my child's dental needs, cleanings, any recommended dental treatment mutually agreed upon and the use of appropriate medication, therapy and administration of anesthetic agent indicated for such treatment.

Initial: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. Dr. Paul and his associates will provide an environment that will help children learn to cooperate during treatment by using praise, explanation, and demonstration of procedures and instruments using variable vocal tonalities.

Initial: _____

By signing below, you consent to the use and disclosure of your child's Protected Health Information (PHI) by Dr. Tahir Paul, his associates, and his staff for treatment, payment and health care operations as specified on our Notice of Privacy Practices Form. You have the right to review our Notice prior to signing this consent. The terms of this Notice may change and the revise Notice will be posted in our office. It may also be requested by contacting this office at (760)745-7070.

You have the right to request that we restrict our uses or disclosures of your child's Protected Health Information that we are otherwise permitted to make for treatment, payment and healthcare operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding to us. You may refuse to consent to the use or disclosure of your child's PHI, but a written document is required. Under this law, we have the right to refuse services should you choose to refuse to disclose your child's Protected Health Information (PHI).

Initial:

☐ I have reviewed, understood and **AGREE** to the content of the Notice of Privacy Practice. _____

☐ I have reviewed, understood, and **DISAGREE** to the content of the Notice of Privacy Practice _____

☐ I refuse to sign the Consent/Acknowledgement of Notice of Privacy Practice. _____

☐ I acknowledge that a copy of Notice of Privacy Practice was provided and/or received. _____

Print Name: _____ **Date:** _____

Signature: _____

Please specify a detailed reason why you disagree and refuse to sign the Consent/Acknowledgement of Notice of Privacy Practice: _____

_____

_____

APPOINTMENT POLICY

Our office shares the same priorities for your child's well being. We make an effort to schedule appointments for your child's best interest. Dental appointments are an excused absence. Missing school can be kept to a minimum when regular dental care is continued.

Late Policy
Please understand, for a typical 30 minute appointment, tardiness of even 10 minutes can greatly diminish the time and quality care your child should receive. Please understand that if you are more than 10 minutes late, your child's appointment might be rescheduled to another day, where we can allow enough time for his/her visit.

Appointment for siblings
We understand your time is very valuable. We can offer appointments for up to 3 siblings from the same family to come in together for their regular check up appointments. Please understand that we reserve over 1½ hours for your family. If you break this type of appointment, any future scheduling will be for only 2 children at a time. The same tardiness and broken appointment policy applies for sibling appointments.

Failed appointments
Since scheduled appointments are reserved exclusively for each patient, we ask that you please notify our office at least 24 hours in advance if you are unable to keep your regular check-up or consultation appointment. If your child is scheduled for dental treatment, especially under sedation or general anesthesia, our office requires a 48-hour notice if you cannot keep your appointment. Another patient who needs our care could be scheduled if we have sufficient time to notify them. We understand that unexpected things can happen, but we ask for your assistance in this regard.

Our failed appointment policy is as follows:

First failed appointment: $25 Broken Appointment Fee

Second failed appointment: $50 Broken Appointment Fee per patient and/or dismissal from the practice

This is NOT in any way an attempt to punish a patient for unexpected emergencies (i.e. sudden illness, accidents). The fees listed above do not apply to these unforeseen circumstances, unless they are an ongoing issue. If an appointment cannot be kept, please call us at least 24 hours before your appointment to cancel.

We strive to offer the very best quality care to your child. We appreciate your cooperation and understanding.

I have read and understood the Appointment Policies mentioned above and agree to abide by the fee structure as per necessary.

Print Name: _____ **Date:** _____

Signature: _____