Hercules Kids Dentistry

We are excited to welcome you and your family to our practice! We look forward to working with you to maintain your child's oral health.
Please fill out this form as completely as possible. If you have any questions we will be happy to help!

REGISTRATION & HEALTH HISTORY FORM

TELL US ABOUT YOUR CHILD: **TODAYS DATE**__________________

Name:____Child's Nickname:____________________________
Last First MI

Child's DOB: _____/_______/_____ Age:_________________ Grade:_______ Sex: Male Female

Child's Home Phone # :(___________)___________________________________

Child's Home Address:____
City State Zip

PARENT ONE - INFORMATION:

Name:____

DOB:____/______/______ Legal guardian: Y N

Email:____

PARENT TWO-INFORMATION:

Name:____

DOB:____/______/______ Legal Guardian: Y N

Email:____

I consent to Hercules Kids Dentistry using my cell phone number to ____call and/or ____ text regarding appointments and to call regarding treatment, insurance and my account. I understand that I can withdraw my consent at any time in writing.

Cell phone number #1 (________) _________-____________________

Cell phone number #2 (________) _________-____________________

HOW DID YOU HEAR ABOUT US:____

DENTAL HISTORY:

Is this your child's first visit to the dentist? Y N If not how long has it been since the last visit? : __________________________
Has the child ever had a difficult problem with dental work: Y N If yes please explain: ______________________________________

Please check mark reason for seeking dental care:

First Examination	Routine Check-Up	Toothache/Swelling	Cavities
Appearance of Teeth	Crowding	Accident/Injury	Other:

Please Check mark any of the following habits your child has:

Thumb/Finger Sucking	Night time feeding	Pacifier	Snoring
Bottle/Sippy Cup	Mouth Breathing	Grinding/Clenching	Lip Sucking/Biting

Please check mark how you would describe your child's temperament:

Outgoing	Shy	Stubborn	Anxious	Frightened	Regular Kid
Curious	Moody	Friendly	Defiant	High Strung	Cooperative

Notes:____

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MEDICAL HISTORY:

Child's Physician: ____ Date of last Physical Exam: ____/____/_____
Is your child under a physician's care at the present time: Y   N
If yes, please explain: ____
Is your child up to date on immunizations against childhood disease: Y   N

Please check mark Y or N to any of the following conditions your child may have:

Condition		Condition		Condition	
Surgeries/Hospitalizations	Y / N	Neurological Problems	Y / N	Developmental Delay	Y / N
Congenital Birth Defects	Y / N	Seizures/Epilepsy	Y / N	Learning Disability	Y / N
Heart Defects/Valves	Y / N	Thyroid	Y / N	ADD/ADHD	Y / N
Heart Murmur	Y / N	Cancer/Tumor/Leukemia	Y / N	Emotional Disturbance	Y / N
High Blood Pressure	Y / N	Hemophilia	Y / N	Anxiety/Depression	Y / N
Liver Problems	Y / N	HIV/AIDS	Y / N	Autism	Y / N
Kidney Problems	Y / N	Artificial Joints/Bones	Y / N	Cleft Lip/Palate	Y / N
Lung Problems	Y / N	Diabetes	Y / N	Speech & Hearing Impaired	Y / N
Asthma	Y / N	Hepatitis	Y / N	Eye Problems	Y / N
Cystic Fibrosis	Y / N	Acid Reflux	Y / N	Pregnant	Y / N
Tuberculosis	Y / N	Chronic Ear Infection	Y / N	Latex Allergy	Y / N
Sickle Cell Anemia	Y / N	Chronic Sinus Infection	Y / N	Allergies to Drugs	Y / N
Bleeding Disorders	Y / N	Mental Retardation	Y / N	Vegan Diet	Y / N
Methemoglobinemia	Y / N	Cerebral Palsy	Y / N	Milk Casein Sensitivity	Y / N
Rheumatic/Scarlet Fever	Y / N	Down Syndrome	Y / N	Glucose 6 Phosphate Dehydrogenase Def.	Y / N

Please list any other conditions not listed: ____

Allergies: ____

Medications: ____

Dr's Signature: ____

Notes:____

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ACKNOWLEDGEMENT AND AUTHORITY

Since the child is a minor, it becomes necessary that signed permission is obtained from a parent or a guardian before any or all necessary dental services can be rendered. I understand that the information I have given is correct to the best of my knowledge, that will be held in the strictest of confidence and it is my responsibility to inform this office of any change in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

____
Signature of parent or guardian   Date   Relationship to Child

IN CASE THE LEGAL GUARDIAN CAN NOT MAKE THE APPOINTMENT:

In the event that I am unable to bring in my child form an appointment, the following individuals have my permission to accompany my child and make any necessary decisions for my child's care. This includes consenting to any treatment plan changes.

IMPORTANT: The legal guardian must accompany their child/children for the first appointment.

Name: ____________________________________ Contact #: _______________________________

BEHAVIOR MANAGEMENT: INFORMED CONSENT

We encourage you to be involved in your child's dental treatment and to become familiar with the behavior management techniques commonly used. Management methods used in pediatric dentistry are directed toward goals of communication, alleviating fear and anxiety, and building a relationship of trust. The selection of any technique is based on many factors including the age and emotional development of your child.

The following are commonly used behavior management techniques:

-*Tell-Show-Do-*: The dentist or the dental assistant will tell the child about the procedure that is going to be performed. The dentist or dental assistant will then demonstrate to the child the procedure. The third and final step is performing the actual procedure on the child.

-*Positive Reinforcement*: When the child exhibits a positive action, the doctor and the staff will compensate the child with praise and strong acknowledgement of their good behavior.

-*Voice Control-*: When a child is acting disruptive, the dentist may change their tone to bring the child to a more accommodating behavior. The tone of the dentist's voice is direct and caring.

-*Mouth Prop-*: A rubber or metal device placed in the child's mouth to prevent closing when a child has difficulty maintaining an open mouth or refuses to open.

-*Patient Stabilization by Dental Assistant or / Doctor*: Either the Dental Assistant will gently immobilize the patient's arms, legs or head to help perform the procedure.

-*Parental Presence/ Absence*: Parents are welcome in the treatment area. The primary role of the parent in the treatment is to be a silent observer, unless invited by the dentist or staff to help participate in treatment. Occasionally, the parent maybe asked to step out of the room. If asked to leave, please be prepared to do so. The objective is to gain the child's attention, establish communication, and avert negative or avoidance behavior.

EXAM: INFORMED CONSENT

-*X-RAYS and Examination*: I understand that my child will be receiving a dental examination from a state licensed dental practioner. (Amrit Bala DDS or Namrata Bhullar DDS). I understand that while X-rays are taken on my teeth that my child will be exposed to a minimal amount of radiation as part of the necessary requirements to complete a through and comprehensive exam. Hercules Kids Dentistry uses the philosophy "As Low As Reasonably Achievable" (ALARA) in its approach to dental x-rays.

-*Changes in Treatment Plan*: I understand that during treatment it may be necessary to change procedures or add procedures because of conditions discovered while working on the teeth that were not found during examination. I understand that there may be unforeseen changes that may occur during treatment. I understand that whenever possible, I will be informed of any treatment changes in advance. I give my permission to the Dentist to make any and or/all changes and additions as necessary.

-*Drugs and Medications*: I agree to the use of topical and local anesthetics. I understand that antibiotics, analgesics and other medications can cause allergic reactions. The reactions can cause redness and swelling of tissues, pain, itching, vomiting, and /or anaphylactic shock.

I hereby state that I have read and understand all of the above information and give my written and implied consent for my child to be treated by Hercules Kids Dentistry.

Signature of Parent/ Guardian: ___________________________________ Date:___________

OFFICE/FINANCIAL POLICY:

-*Appointment Policy*: Your appointment is reserved specifically for your child. Changes may affect other patients. If a change or a cancellation is unavoidable and conflicts arise, please call our office at least 24 business hours in advance. Our office will always contact your family via phone or email to remind you of your child's appointments. **An appointment without a 24 hour notice will result in a $25.00 fee**.

-*Financial Policy:* The fee for your child's treatment will be based on the extent of treatment required. During your first visit we will discuss the probable number of visits, their length and the fees involved for each visit.

-*Patient with Dental Insurance*: As a courtesy to our patients with in network and out of network dental insurances, we will contact your insurance company and estimate what your initial copayment will be. **If copayment is due, it will need to be received in full on the day of the treatment appointment**. In addition, it is the policyholder's responsibility to ensure coverage is intact. Please keep in mind; this is only an estimate and coverage verification does not guarantee payment. It also does not guarantee the estimated cost given to you is the total amount due. If an amount is due we will notify you prior to mailing a bill to inform you of why your insurance did not cover the amount.

-*Patients without Dental Insurance*: Patients who do not have any dental insurance are required to pay in full by the completion of treatment/each visit.

Refund/ Remaining Balance: If your insurance company pays more than the estimated copayment amount given to you, you will be sent a refund check. This check will be sent you within one week of receiving payment from the insurance company. If your insurance company pays less than the estimated copayment amount given to you, you will be required to pay the remaining balance amount.

-Care Credit: For your convenience, we do offer an interest free financing plan. Care Credit is a line of credit exclusively for your healthcare needs. Once approved, payments can be broken down into a 6 or 12 month plan. Please visit www.carecredit.com for more information and details.

Signature of Parent/Guardian:_______________________________Date:___________

MISSED/LATE APPOINTMENT/LATE CANCELLATION OFFICE POLICY:

Showing up late or missing an appointment takes time away from a child who might really need that time. Which is why if you arrive 15 minutes later than your appointment, you will be asked to reschedule unless our doctor's schedule can still accommodate you. This will count as a missed appointment. Two missed appointments we will have to dismiss you from our practice. There is no charge for the **FIRST** missed/late cancelled appointment. There will be a $50 charge for a second missed/late cancelled exam appointment and a $100 charge for a second missed/late cancelled operative appointment. Please notify our office **24 HOURS IN ADVANCE** if you cannot make it to your child's dental appointment to avoid these charges. While we make every effort to provide a reminder call at least 24 hours before your appointment, **it is your responsibility to remember your appointment**. By signing this form you have read and understood our office policy.

Signature of Parent/Guardian:_______________________________Date:___________

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT:

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can be used to:

-Conduct, plan and direct my or my child's treatment and follow up among the multiple health care providers who may be involved in that treatment directly and indirectly.
-Obtain payment from third-party payers.
-Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understood your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used, or disclosed, to carry out treatment, payment or health care operations. I also understand you are not required to agree to my restrictions, but if you do agree then you are bound to abide by such restrictions.

Signature of Parent/Guardian:_________________________________ Date:_________