# Kids Dental Now

Dentistry for Children & Teens

2500 E. Hallandale Beach Blvd., Suite M Hallandale Beach, FL 33009
**Phone: 954.951.3001 Fax: 954.228.2199**

## 1. Tell us about your child

Child's name: ______________________________

Child's birthdate: ____/____/____ M F

Siblings: YES NO Do we treat them: YES NO

Child's reach phone #: ____________________

Child's home address: ____________________

__________________________________________

Does child has dental insurance: YES NO

What type of dental insurance:

Medicate PPO HMO DHMO Other

## 2. Who may we thank for referring you?

__________________________________________

## 3. Parent/Legal guardian information

Name: ____________________________________

Mother Father Other ___________

Phone #: (_______) __________-____________

Do you have the same address as the child: Y N

Are you the legal guardian: YES NO

## 4. Complete ONLY if child's insurance is PPO/HMO/DHMO

*Name of the insurance:* ______________________

*Primary insurance holder information*

Name: ____________________________________

Date of birth: ______/_______/______

SSN #: ________-__________-_________

Address: __________________________________

__________________________________________

Phone #: (_______) _________-_____________

Member ID: ________________________________

Group ID: _________________________________

*Employer information*

Employer's name (Company name): _______________

Employer's address: __________________________

__________________________________________

Employer's phone #: (______) _______-__________

## 5. Dental History

First dental visit: YES NO

Last dental visit: ______ month/years ago

Did your child ever hurt his/her teeth: YES NO

Does your child have any dental pain: YES NO

Do you give the child any fluoride supplements: Y N

Does your child have any of the following habits ?

Thumb sucking Breastfeeding
Tongues sucking Pacifier
Nail biting Bottle feeding

Flossing YES NO

Brushing: Once/day Twice/day Rarely

## 6. Medical history

Is your child seen by a physician: YES NO

Name of physician: ___________________________

Physician's phone #: (______) _________-_________

Is child allergic to medication/other allergens: Y N

Name the allergen: ___________________________

Is your child taking any medication: YES NO

Name medication and dose ____________________

__________________________________________

Is your child diagnosed with any medical condition (disease)? YES NO _________________

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## GENERAL CONSENT

Welcome to Kids Dental Now! In order to serve you the best we need you to consent to our office policies. Please initial the following:

______ I understand and authorize the dentists to release any information necessary, including diagnosis and any record of examination and treatment, rendered to my child or me during the period of dental care to other health care provider and/or third-party payers and/or to the following person (complete only if realize of medical records requested):
Name: ________________________________ Relationship with the patient: _________
Phone #: (_____)_______-_______
e-mail: ____________________________________________
______ I authorize and request my insurance company to pay directly to the dentist any insurance benefits otherwise payable to me. I agree and understand that I am responsible for any balance remaining after the insurance carrier payment.

_______ I authorize and request the dental staff from Kids Dental Now to perform necessary dental services to my child, including but not limited to dental treatment, x-rays and administration of anesthetics that are deemed advisable by the dentist whether or not I am present in the room where the treatment is rendered.

Complete only if you do not want the following. I DO NOT allow the following for my child:
_________ Fluoride treatment
_________ X-Ray
_________ Sealants
_________ Prophylaxis

________ I authorize Kids Dental Now to confirm the appointments via text message, phone calls, appointment cards and e-mails.
________ I authorize Kids Dental Now to post on social media pictures/statements/first name/ drawings of my child inside dental office only with my verbal consent.
________ Kids Dental Now will work with you to serve your child's dental needs the best by appointing next visits as soon as possible. Broken appointments add to the cost of providing care for all our patients. Unconfirmed dental appointments will automatically be deleted from the schedule and need to be rescheduled. Our office standard policy regarding broken appointments is as follows:
New patient/ Recall: $25
Restorative procedure: $35
Patient scheduled for oral rehabilitation under general anesthesia: $75
By signing and dating this page I agree that all the information is accurate and accordingly to my child's medical and legal status as per my best knowledge. I also red and acknowledged the HIPPA regulations of the dental office.

Name of Parent/Legal Guardian: ________________________ Signature: _____________
Date: ______/_______/________