Child's Name:_____ **Date:**_____

COMMENTS: *(for office use only)*

Med hx updated in chart?	**Dr. Initials**

MEDICAL HISTORY:

1. Name of pediatrician_____ Phone #_____
2. Is your child under the care of another physician/specialist? ☐ Yes ☐ No
   If yes, who? Since when and why?_____
3. Is your child receiving any medication? ☐ Yes ☐ No
   List current medications:_____
4. **Is your child allergic to <u>any</u> drugs**, such as penicillin? ☐ Yes ☐ No
   Explain:_____
5. Does your child have other allergies? ☐ Yes ☐ No
   Explain:_____
6. Has your child had any serious illness? ☐ Yes ☐ No
   Explain:_____
7. Has your child ever had surgery or been hospitalized? ☐ Yes ☐ No
   When & Why?:_____
8. Has your child had a history of any of the following? **Please check a response for each question:**

Heart trouble, heart murmur, or heart surgery ☐ Yes ☐ No
Rheumatic fever or scarlet fever ☐ Yes ☐ No
Asthma, TB, or lung problems ☐ Yes ☐ No
HIV infection or AIDS ☐ Yes ☐ No
Hemophilia or bleeding problems ☐ Yes ☐ No
Sickle cell anemia/blood disorder ☐ Yes ☐ No
Hepatitis or liver problems ☐ Yes ☐ No
Kidney infection ☐ Yes ☐ No
Diabetes ☐ Yes ☐ No
Congenital birth defects ☐ Yes ☐ No
Cleft lip or palate ☐ Yes ☐ No
Malignant hyperthermia ☐ Yes ☐ No
Is parent or patient pregnant? ☐ Yes ☐ No
Thyroid or other glandular problems ☐ Yes ☐ No
Latex or rubber allergy ☐ Yes ☐ No
Cancer, tumor, leukemia ☐ Yes ☐ No
Describe:_____

Epilepsy, seizures, fainting ☐ Yes ☐ No
Describe:_____

Cerebral palsy or developmental delay ☐ Yes ☐ No
Describe:_____

Vision problems ☐ Yes ☐ No
Describe:_____

Speech or hearing problems ☐ Yes ☐ No
Describe:_____

Emotional or psychological problems ☐ Yes ☐ No
Describe:_____

DENTAL HISTORY

1. When and where was your child's last dental visit? _____
2. What was the purpose of that visit?_____
3. Did your child have difficulty cooperating? ☐ Yes ☐ No
4. Does your child take fluoride supplements? ☐ Yes ☐ No
5. Have any cavities been noted in the past? ☐ Yes ☐ No
6. Were any teeth (baby or permanent) removed by extraction? ☐ Yes ☐ No
7. Have there been any injuries to teeth, such as falls, chips, etc.? ☐ Yes ☐ No
8. Does your child have other siblings seen by us? ☐ Yes ☐ No If Yes, please list their name(s):_____
9. Is there any additional information that we should know to help ensure a positive experience for your child? _____

_____

CONSENT

I understand that the information I have given is correct and to the best of my knowledge, and that it will be held in the strictest of confidence. Because my child is a minor, it is necessary that signed permission be obtained from a parent or legal guardian before any dental services can be rendered. I give my consent to Dr. Beth E. Kailes and her staff to perform such treatment, services, medication, behavior management techniques, local anesthesia and/or analgesia necessary to treat any dental/oral deficiency, abnormality, and/or infection.

_____ _____

Signature of Parent/Guardian Date

Pediatric DENTISTRY
Growing Healthy Smiles

Beth E. Kailes, DMD - Nicole M. Staman, DMD - Allison J. Johnston, DMD
2013 Town Center Blvd. Fleming Island, FL 32003
904-215-7800 DrBethKailes.com

Patient Registration Form

Tell us About your Child

Child's First Name:_____ MI:____ Last:_____ Preferred Name:_____ ◯Male ◯Female

Child's Date of Birth:_____ Child's Age:_____ School:_____ Grade:_____

Child's Home Address:_____ City:_____ State:____ Zip:_____

Child's Primary Phone#: (____)_____ ☐Home ☐Cell (Mom) ☐Cell (Dad) ☐Work (Mom) ☐Work (Dad)

Child's Secondary Phone#: (____)_____ ☐Home ☐Cell (Mom) ☐Cell (Dad) ☐Work (Mom) ☐Work (Dad)

Child resides with (check all that apply): ☐Mom ☐Dad ☐Stepmom ☐Stepdad ☐Grandparent ☐Other:_____

Who has legal custody of the child (check all that apply): ☐Mom ☐Dad ☐Stepmom ☐Stepdad ☐Grandparent ☐Other:_____

Who is Accompanying the Child Today?

Name:_____ Relationship:_____ Do you have legal custody of the child? ☐ Yes ☐ No

Emergency Contact Name: _____ Phone #:_____ Relationship:_____

Whom may we thank for this referral?_____

Person Responsible for Account

Mother's Information:

Name:_____ DOB:_____

Address:_____

_____

Employed by:_____

Occupation:_____

Business phone #:_____

Home phone #:_____ Cell:_____

Email address: _____

Drivers License #:_____

Marital Status: ☐ Single ☐ Divorced ☐ Widowed

☐ Married to:

Father's Information:

Name:_____ DOB:_____

Address:_____

_____

Employed by:_____

Occupation:_____

Business phone #:_____

Home phone #:_____ Cell:_____

Email address: _____

Drivers License #:_____

Marital Status: ☐ Single ☐ Divorced ☐ Widowed

☐ Married to:

Dental Insurance

Insurance Co. Name:_____ Insurance Co. Phone #:_____

Insurance Co. Address:_____

Group # :_____ ID, Plan or Policy# :_____

Insured's Name:_____ SS#:_____ Insured's DOB:_____

Insured's Employer:_____ Relationship to Child:_____

Authorization

I certify the truth of all information provided. I also authorize the release of pertinent information to those persons requiring it for the treatment of my child or for the purpose of payment of the account or credit reference. Under certain circumstances, I authorize payment of insurance benefits directly to Dr. Kailes, otherwise payable to me. **I understand that my dental insurance carrier may pay less than the actual amount billed for services and may not cover all services provided.** I understand I am financially responsible for payment of services not paid, in whole or in part, by my dental care payor.

_____ _____

SIGNATURE OF PARENT/GUARDIAN DATE

Pediatric DENTISTRY
Beth E. Kailes, D.M.D., P.A.
Growing Healthy Smiles

OFFICE FINANCIAL POLICY

We are pleased you have chosen our office for you child's dental care. We are dedicated to providing the best treatment for our patients and fees are based on the most appropriate treatment for your child. We need your understanding and cooperation in the following guidelines regarding the filing of your insurance claims and payment.

INSURANCE:

*Our office may be contracted as a *preferred provider* for your insurance company. If your insurance is through a company with whom we are not contracted, please check your contract carefully to determine if you are required to see a preferred provider for that company. Understand that if you choose to see a *non-preferred provider*, your insurance may not pay the full amount or pay at all.

*All applicable deductibles, co-payments, and co-insurance amounts are due at the time services are rendered. We accept cash, checks, Master Card, Visa, Discover, American Express and Care Credit. Some dental services may not be covered by your contract. In the event a given procedure is not covered for any reason (i.e. frequencies limitations, benefit maximum reached) payment for these services is your responsibility. You are responsible for payment regardless of any insurance company's arbitrary determination of fees.

*While the filing of insurance claims is a courtesy we gladly extend to you, ALL CHARGES ARE ULTIMATELY YOUR RESPONSIBILITY FROM THE DATE SERVICES ARE RENDERED. OUR SYSTEMS ARE NOT ABLE TO TRACK LIMITATIONS (FREQUENCY, AGE, WAITING PERIOD, ETC.). IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR PLAN'S LIMITATIONS.

*****WE CANNOT GUARANTEE WHAT INSURANCE WILL PAY*****

Dr. Kailes recommends doing fluoride treatments on children every six months. The frequency of x-rays depends on your child's risk for decay and individual needs. Please be aware that your insurance may or may not cover the fluoride or x-rays recommended even if they are medically necessary.

I authorize the recommended fluoride treatment for my child/children even though my insurance may not cover it. I understand that I am responsible for all charges if my insurance does not cover the procedure.
Yes _____ No_____

I authorize the recommended x-rays for my child/children even though my insurance may not cover them. I understand that I am responsible for all charges if my insurance does not cover the procedure.
Yes _____ No_____

RETURNED CHECKS – COLLECTIONS:

*A charge of $25.00 will be assessed on any returned checks.

*A service fee up to 50% of the balance will be added to accounts turned over to our collection agency and you will be responsible for any additional collection fees.

CANCELLATIONS & FAILED APPOINTMENTS:

*A 24 hour notice is required for cancellation of an appointment. There is a $35 fee for missed or cancelled appointments without 24 hour notice.

HIPAA AUTHORIZATION:

I acknowledge that I have received a copy of the Notice of Privacy Practices of Dr. Beth E. Kailes, DMD, P.A.

RESPONSIBLE PARTIES:

a. **Responsible Party** – All minors under the age of 18 must be accompanied by a parent or legal guardian for the first office visit. Legal guardians must present court ordered documentation of guardianship at time of check-in.
b. **Minor Children of Divorced Parents** – Payments, co-pays, co-insurance and deductibles are due at the time of service. It is our office policy that all correspondence, medical and financial, is sent to one address, usually where the child resides. It is up to the parents to decide how best to communicate between households, information and concerns regarding your children. We will not bill separate households for payment. Parents should work out the arrangements between themselves. REGARDLESS of what your divorce decree states, we are not part of that settlement.
c. **Financial Responsibility of Both Parents or/and All Legal Guardians** – The stated terms of this Financial Policy shall not modify the duty of both parents or/and all legal guardians to provide for the welfare of their minor children. We expressly reserve the right to hold either or all parents/legal guardians responsible for any and all reasonable and necessary medical expenses.

COMMUNICATIONS:

*Our office may use multiple types of communication in order to serve you best. By supplying any contact information, you give authorization for our office to contact you by any and all phone numbers, mailing addresses and email addresses provided, including text messaging and unencrypted email messages. You may opt out of these communications by notifying our office at any time. Your contact information is confidential.

By my signature, I acknowledge the above office financial policy & HIPAA authorization and agree to comply with said policy.

Signature of Responsible Party: _____ **Date:**_____

Responsible Party Name:_____

Patient name/s:_____