

Do you assist your child with tooth brushing? ___ Yes ___ No

Do you assist your child with flossing? ___ Yes ___ No

How many times a day does your child brush? _____

How many times a week does your child floss? _____

Medical History

Is your child under the care of a physician/pediatrician for a specific reason? ___ Yes ___ No If yes, please explain: _____

Doctor's Name: _____ Doctor's Address: _____

Is your child currently taking any medications? ___ Yes ___ No Please list: _____

Has your child ever had surgery? ___ Yes ___ No Please explain: _____

Preferred Pharmacy

Pharmacy Name

Location

Allergies

For the following questions, please mark an (X) for your responses

Allergic or Adverse Reaction to?	Yes	No	?	Allergic or Adverse Reaction to?	Yes	No	?
Aspirin?				Latex?			
Penicillin, Amoxicillin or Augmentin®?				Metals?			
Other Antibiotics? Please List:				Local Anesthetics?			
Codeine?				Others? Please List:			

Medical Conditions

Medical Condition	Yes	No	?	Medical Condition	Yes	No	?
Recurrent Infections?				Autoimmune disease?			
Eating Disorder?				Anemia?			
Arthritis?				Gastrointestinal Disorder?			
Asthma?				Attention Deficit Disorder (ADD)?			
Autism?				Behavior/Learning difficulties?			
Epilepsy/seizures?				Bleeding disorder?			
Bone/Joint/orthopedic problem?				Speech difficulty?			
Organ transplant?				Mononucleosis?			
Cerebral Palsy?				Diabetes?			
Hearing difficulties/Hearing aids/implants?				Repaired Cleft lip and or palate?			
Heart Problems or previous heart surgery?				Hemophilia?			
Genetic disorder?				Hepatitis B or C?			
HIV+/AIDS?				Kidney disease?			
Liver Disease?				Shunt?			
Tuberculosis (TB)?				Damaged valves in a transplanted heart?*			
Unrepaired, Cyanotic Congenital Heart Disease?*				Repaired Cyanotic Congenital Heart Disease in the past 6 months?			
Repaired Congenital Heart Disease with Defects?*				Other?			

Antibiotics prior to your child's dental treatment may be necessary for the conditions marked with an asterisk symbol

Is there any other information that we need to be aware of regarding your child that has not been covered on the questionnaire? ___ Yes ___ No

Please explain: _____

Is there anything you would like to share with me in private without your child being present? ___ Yes ___ No

Please explain: _____

I hereby certify that I have read and understand the previous information and that it is accurate and true to the best of my knowledge. I understand the importance of a truthful health history and that Dr. Kinsler and her staff will rely on this information for treating me. I acknowledge that providing incorrect and/or inaccurate information has the potential of being hazardous to my health. I acknowledge that my questions, if any, about inquiries set forth above have been answered to my satisfaction. I will not hold Dr. Kinsler, or any other member of her staff, responsible for any action they take or do not take because of errors or omissions that I have made in the completion of this form. I authorize the diagnosis of my dental health by means of radiographs or other diagnostic aids deemed appropriate. I authorize Kinsler Family Dentistry to release any information including the diagnosis and records of treatment or examination for myself and my dependent(s) to third-party insurance carriers, payors, and/or healthcare practitioners via paper or electronic transmission.

Patient or Responsible Party Signature: _____

Date: _____

Reviewed by Dr. Kinsler: _____

Date: _____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY POLICIES

I have been provided access to Kinsler Family Dentistry's Notice of Privacy Practices (available both online and in the office) and have had full opportunity to read and consider its terms. I understand that the Notice of Privacy Practices governs how Kinsler Family Dentistry may use and disclose my protected health information and how I can get access to my protected health information.

Patient or Responsible Party Initials (Please Print): _____

AUTHORIZATION TO RELEASE INFORMATION

Many patients allow family members such as their spouse, parents, or others to call and request information regarding treatment and/or financial information. Under the requirements for H.I.P.A.A., we are not allowed to provide this information to anyone without the patient's consent. If you wish to have your information released to anyone other than yourself, you must complete this form.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

I authorize Kinsler Family Dentistry to release my own or my dependents information to the following individuals (if applicable):

***PARENT OR GUARDIAN INFORMATION SHOULD BE ENTERED IF PATIENT IS UNDER 18.**

Name (Please Print): _____ Relationship: _____ Phone # _____

Name (Please Print): _____ Relationship: _____ Phone # _____

Name (Please Print): _____ Relationship: _____ Phone # _____

Patient or Responsible Party Initials (Please Print): _____

CONSENT TO RECEIVE ELECTRONIC COMMUNICATIONS

Patient or Responsible Party Initials (Please Print): _____

(Initial Below)

I _____ DO AGREE

I _____ DO NOT AGREE

that Kinsler Family Dentistry may communicate with me electronically at the email address and/or mobile phone number listed below.

Mobile Phone Number: _____

Email Address: _____

I am aware that there is some level of risk in receiving any form of electronic communications. I further agree that I am responsible for providing the dental practice any updates to my email address and/or mobile phone number.

I can withdraw my consent to electronic communications at any time by contacting:

Kinsler Family Dentistry via phone (765) 659-2124 or email info@kinslerfamilydentistry.com.

By signing this document, I am acknowledging the receipt of Notice of Privacy Practices, authorizing The Release of Information as instructed above, and consenting to my above election regarding Electronic Communications.

Patient or Responsible Party Name (Please Print): _____

Patient or Responsible Party Signature: _____ **Date** _____



FINANCIAL POLICY

Thank you for choosing Kinsler Family Dentistry for your dental care! Our entire team is dedicated to helping you achieve and maintain long-term dental health and a beautiful smile by making every effort to provide treatment plans that fit within your budget. We accept cash, personal checks, Visa, MasterCard, Discover, and American Express. We are also pleased to offer our patients the CareCredit® card, North America's leading patient payment program. CareCredit lets you begin your treatment immediately, then pay for it over time with low monthly payments that fit easily into your monthly budget. All financial arrangements must be completed prior to the procedure being completed.

Patients with Dental Insurance:

Kinsler Family Dentistry will file dental insurance claims as a courtesy to our patients. In order to benefit from this service, I agree to provide updated insurance information prior to each appointment or upon request. I understand that I am responsible for any applicable deductibles and/or estimated patient portions of fees at the time of service. I authorize payment for services rendered to be paid by any third party; including, but not limited to, insurance carriers directly to Kinsler Family Dentistry.

As the contractual obligation with the insurance company is between you and your insurance carrier, we do recommend you make yourself familiar with your insurance benefits prior to visiting the office. We will work hand in hand with you to maximize your insurance reimbursement for covered procedures, however Kinsler Family Dentistry is not responsible for how your insurance company handles claims or for what benefits are paid or unpaid on a claim. Our office can only assist you in **estimating** your portion of the cost of treatment. We at no time **guarantee** what your insurance will or will not do with each claim.

Patients without Dental Insurance:

Full payment is required at the time of service unless prior financial arrangements have been completed.

Delinquent Accounts and Fees:

Delinquent accounts will be required to pay all past due balances in full prior to receiving new treatment or incurring new charges for services or products. All future charges for services or products must be paid at the time services or products are rendered. A \$5.00 re-billing fee may be applied to accounts exceeding 60 days past due. A \$40.00 charge will be applied to all returned checks. I agree to reimburse Kinsler Family Dentistry for all costs and expenses including attorney's fees and court fees, incurred in our collections efforts. In the event of a suit, I agree the venue shall be in Clinton County, Indiana. I acknowledge that any demographic information provided by me, including home and mobile phone numbers, may be used to contact me for any purpose, including collections efforts.

Custody Agreements:

The parent/guardian that brings the dependent child to the dental visit will be the responsible party for paying all fees incurred on that date of service. If there are unpaid balances, this parent/guardian will be held solely responsible for any balances and/or fees related to that date of service. Kinsler Family Dentistry will not be responsible for or take any part in communicating with the other parent/guardian to resolve issues related to appointment scheduling or payment.

I hereby certify that I have read, understand, and agree to all content within the Financial Policy as stated above:

Patient or Responsible Party Name (Please Print): _____

Patient or Responsible Party Signature: _____ ***Date*** _____



CANCELLATION POLICY

Please understand that Kinsler Family Dentistry does not overbook our schedule to accommodate for patients that fail or miss their scheduled appointment(s). We reserve your appointment time specifically for you and realize that emergencies and other scheduling conflicts arise and are sometimes unavoidable. However, short notice cancellations and/or no-shows result in lost opportunities for our dental practice to operate at its most efficient level. This policy is in place out of respect for all of us, including you.

Late Arrival Policy:

Patients are asked to arrive at their appointments before their scheduled appointment time. A grace period of 10 minutes will be permitted for unforeseen delays a patient may encounter while traveling to the office for their scheduled appointment. If a patient arrives more than 10 minutes late for their appointment, the patient may be seen if the schedule permits, or will be rescheduled for a later date. This process will ensure patients who do arrive on time are seen in a timely manner.

No-Show/Cancellation Policy:

A failed appointment is an appointment that is cancelled or rescheduled without 24 hours' notice or an appointment where a patient does not show up at all. **A \$40.00 fee may be applied for any failed appointments that occur within 24 hours of your scheduled appointment time.** This charge cannot be billed to insurance and must be paid on or before your next scheduled appointment.

Our team makes every possible effort to keep you informed of upcoming appointments through a robust appointment reminder and confirmation process:

- 1) If you schedule a follow-up appointment in our office, you will leave with an appointment card and/or a printed walkout statement that includes the time and date for your next appointment(s)
- 2) Patients receive appointment reminders via text/email 7 days prior to the scheduled appointment
- 3) Patients then receive appointment confirmation requests via text/email 2 days prior to their scheduled appointment
- 4) If patients have not responded to the confirmation request, our office will then attempt to contact you via phone to confirm your upcoming appointment

It is the patient's responsibility to cancel or reschedule the appointment no less than 24 hours prior to their scheduled appointment. A pattern of failed appointments may result in a limitation to schedule same-day appointments only, up to and including dismissal from our practice.

NOTE: You will never be charged for a cancellation if it is made more than 24 hours in advance of your scheduled appointment time.

I hereby certify that I have read, understand, and agree to all content within the Cancellation/No-Show Policy as stated above:

Patient or Responsible Party Name (Please Print): _____

Patient or Responsible Party Signature: _____ ***Date:*** _____