Kinsler Family Dentistry

Patient Registration and Health Information Questionnaire

(Ages 1 - 17)

Welcome to Kinsler Family Dentistry! Our office adheres to written policies and procedures to protect your privacy. This information is for our records only and will be kept confidential subject to applicable laws. Please note that you may be asked additional questions regarding your responses to this questionnaire and there may be additional questions concerning your health history. This information allows us to provide the best possible care for you during your visit.

Today's Date: _____

Child's Information:

Child's Name: _____ Date of Birth: _____ Sex: ___ M ___ F
First Last Middle

Child Lives with: ____ Both Parents ___ Mother ___ Father ___Other:_____

Mother's Name: _____ Preferred Contact Number: _____

Father's Name: _____ Preferred Contact Number: _____

Address: _____ SSN: _____
Street Address City State Zip Code

Home Phone: ( ) _____-_____ Cell Phone: ( ) _____-_____ Work Phone: ( ) _____-_____ E-mail: _____

Emergency Contact: _____ Relationship: _____ Phone Number: ( ) ____-_____

Child's Favorite Sport/Activity/Hobby: _____ School Name: _____ Grade:_____

Who is completing this form today? _____ Who is responsible for making appointments? _____

Whom may we thank for referring you to our office? _____

Insurance Information:

Primary Dental Insurance:

Insured Name: _____ Insured Date of Birth: _____ Insured SSN: _____

Employer: _____ Address: _____
Street Address City State Zip Code

Secondary Dental Insurance:

Insured Name: _____ Insured Date of Birth: _____ Insured SSN: _____

Employer: _____ Address: _____
Street Address City State Zip Code

I authorize the disclosure of my records (or my child's records) to Kinsler Family Dentistry. This authorization will remain in effect until I revoke it in writing. I authorize payment directly to Kinsler Family Dentistry of the insurance benefits otherwise payable to me. I understand and agree that I am responsible for payment of all services including any co-insurance (co-payments), deductible or services not covered by my insurance.

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

Dental History

Please check the reason(s) for today's dental visit:

___ First dental visit ___ Routine Check up and cleaning ___ Crowded, crooked teeth ___ Braces ___ Pain or swelling ___ Cavities ___ Other

Has your child ever had any injuries to the mouth, head or teeth? ___ No ___ Yes:_____

Has your child ever had any problem with dental treatment in the past? ___ No ___ Yes: _____

Has your child ever had any orthodontic treatment (braces, retainers, space maintainers)? ___ No ___ Yes: _____

Has your child sucked his/her thumb, fingers, or pacifier? ___ Yes ___ No Does the habit still exist? ___ Yes ___ No

Please describe your child's temperament? ___ Friendly ___ Talkative ___ Quiet/shy ___ Unmanageable ___ Nervous/frightened ___ Active

___ Independent ___ Stubborn ___ Strong-willed ___ Other: _____

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? _____

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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 certify that I have read and understand the above and that the information given on this form is accurate. 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 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.

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

Reviewed by Dr. Kinsler:_____ **Date:**_____

Kinsler Family Dentistry - Current Medication List

Patient Name: _____

Date of Birth: ___/___/_____

Please include Non-prescription medicines and supplements
It helps if you bring your bottle with you to your appointments.

ALLERGIES? *(please list below)*

_____

Medicine/Supplement Name	Dosage? (mg, etc.)	What is this taken for?

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 Name (Please Print): _____

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

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 Name (Please Print): _____

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

CONSENT TO RECEIVE ELECTRONIC COMMUNICATIONS

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

(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.

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

FINANCIAL POLICY

Thank you for choosing Kinsler Family Dentistry for your oral health care needs! 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 service charge of 1.5% per month (18% per year) on the unpaid balance or $4.00 rebilling charge, whichever is greater, will 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 attorneys 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.

Appointments, Timeliness, and Communication

We are committed to seeing you on-time and request that you arrive on-time for your visits. Please remember that appointments are reserved specifically for you, and that short notice cancellations result in lost opportunities to get other patients scheduled. We request at least 24 hours prior notice be given if an appointment needs to be rescheduled. If appointments are missed or rescheduled without 24 hours' notice, you may be charged a fee. A pattern of missed appointments (no shows) and/or short notice cancellations (less than 24 hours) may result in a limitation to schedule same-day appointments only, up to and including dismissal from our practice.

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*** _____