DENTISTRY FOR KIDS
1439 S St. Francis Dr, Santa Fe, NM 87505
(505) 473-5437

DENTISTRY FOR KIDS *SOUTHSIDE*
6640 Cerrillos Rd., Ste E, Santa Fe, NM 87507
(505) 473-5437

PATIENT INFORMATION

Date: _____

Name _____ Preferred Name _____
Birthdate _____ Male _____ Female _____ NB _____
Child's Social Security Number _____ Current Age _____
Name of Parent/Guardian filling out form _____
Parent/Guardian #1 Name _____ Marital Status _____
Parent/Guardian #1 Social Security Number _____ Parent/Guardian #1 Birthdate _____
Parent/Guardian #1 Mailing Address _____
City _____ State _____ Zip _____
Home Phone _____
Work Phone _____
Cell Phone _____ Preferred Contact Number (check one): Home _____ Cell _____
Email Address _____
Do you allow us to contact you via email or text to communicate patient information? ☐ YES ☐ NO
Parent/Guardian #2 Name _____ Marital Status _____
Parent/Guardian #2 Social Security Number _____ Parent/Guardian #2 Birthdate _____
Parent/Guardian #2 Mailing Address _____
City _____ State _____ Zip _____
Home Phone _____
Work Phone _____
Cell Phone _____ Preferred Contact Number (check one): Home _____ Cell _____
Email Address _____
Do you allow us to contact you via email or text to communicate patient information? ☐ YES ☐ NO

DENTAL INSURANCE INFORMATION

If you receive financial assistance for your child's dental care, please check the option that applies:

Medicaid _____ CMS _____ Project ANN _____ Other _____

Primary Policy Information

Name of Policy Holder _____
Insurance Name _____ Insurance Phone Number _____
Member ID _____ Group # _____
Policy Holder's Birthdate _____
Policy Holder's Social Security Number (required to file claims) _____
Employer _____
Phone _____
Person other than spouse to be notified in case of an emergency _____
Phone _____
Medical Physician _____ Phone _____

Secondary Policy Information

Name of Policy Holder _____
Insurance Name _____ Insurance Phone Number _____
Member ID _____ Group # _____
Policy Holder's Birthdate _____
Policy Holder's Social Security Number (required to file claims) _____
Employer _____

Patient Name _____

Is this your child's first visit to a dentist? yes ☐ no ☐

Was your previous dentist experience: good ☐ bad ☐ other ☐ Explain: _____

Please tell us the main reason for today's visit: _____

_____

Has your child been experiencing dental pain? yes ☐ no ☐

Has your child been awake at night from dental pain? yes ☐ no ☐

Do you have any concerns about your child's dental health? _____

Has your child ever been hospitalized? yes ☐ no ☐ If yes, please give date(s) & reasons:

_____

Is your child allergic to any medications? yes ☐ no ☐ If yes, please identify: _____

_____

Is your child currently taking any medications? yes ☐ no ☐ If yes, please identify: _____

Reason for medication _____

Pediatrician Name _____ Phone _____

Has your child been immunized for: DPT: yes ☐ no ☐

Polio: yes ☐ no ☐

Measles, Mumps & German Measles: yes ☐ no ☐

Is there anything you can tell us about your child that could assist us in taking the best possible care of them? _____

_____

HEALTH HISTORY

This information will be confidential and is necessary to allow us to give your child our best treatment. Please check yes or no to whether your child have or have they ever had in the past any of the following:

YES	NO		YES	NO	
☐	☐	Speech problems	☐	☐	Anemia/Sickle Cell Disease
☐	☐	Cerebral Palsy	☐	☐	Hearing problems
☐	☐	Bruises easily	☐	☐	Seizures
☐	☐	Asthma	☐	☐	Blood transfusion
☐	☐	Kidney/bladder problems	☐	☐	Skin problems
☐	☐	Hepatitis/jaundice	☐	☐	Diabetes
☐	☐	Cystic Fibrosis	☐	☐	Pregnancy (patient)
☐	☐	Allergies, if so, what: _____			

Has patient had heart disease or a heart murmur? yes ☐ no ☐ If yes, please describe: _____

_____

Is pre-medication required for dental treatment? yes ☐ no ☐ Preferred drug: _____

Child's weight: _____

Please *check* all illnesses your child has previously had:

☐ Chicken Pox ☐ Ear Aches ☐ Measles ☐ German Measles ☐ Mumps ☐ Mononucleosis ☐ HIV/AIDS ☐ Scarlet Fever
☐ Tuberculosis ☐ Venereal Disease ☐ Tonsillitis

Learning or behavior disorders: yes ☐ no ☐ If yes, what: _____

Has your child had any prior surgeries? yes ☐ no ☐ Is your child currently scheduled for surgery? yes ☐ no ☐

If yes, describe/date: _____

Is your child a picky eater? yes ☐ no ☐

Is there anything else we should know about your child? _____

_____

Parent/Guardian Signature: _____

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION
DENTISTRY FOR KIDS

Section A: Patient Giving Consent

Patient's Name _____

Section B: To the Parent or Guardian (please read the following carefully)

Purpose of consent: by signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.
Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, uses and disclosures of your protected health information and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing.
We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice at any time by contacting:

Dentistry For Kids
Office (505) 473-5437
Fax (505) 438-3443
1439 S St. Francis Dr, Santa Fe, NM 87505
Santa Fe, NM 87505

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature:

I, _____ have had full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature _____ **Date** _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: _____
Relationship to Patient: _____

Dear Responsible Party: Dentistry for Kids may use the following treatment aids in caring for your child. We will discuss with you their use when applicable, however please familiarize yourself with them.

Nitrous Oxide/Oxygen: This gas mixture is administered through a nose mask; its main purpose is to help reduce anxiety, although it also reduces the perception of pain. Patients do not go to sleep as they are always receiving at least 40% oxygen. Very rare side effects might include nausea, vomiting and dizziness. The effects of the gas end within minutes after stopping its use.

Local Anesthesia: This may be in the form of a topical gel/cream or an injectable liquid. It is used to produce anesthesia of the hard and soft tissues. Allergies are rare, but could include rash, skin eruptions and anaphylactic shock, which could be deadly without prompt medical management. Children must be constantly reminded not to bite or chew on the soft tissue in the anesthetized area.

Therapeutic Supports (i.e., Occupational therapy, Speech therapy, Physical therapy): may be recommended based on the child's needs.

Rubber dam application: This consists of a clamp that fits over the tooth and a thin piece of rubber that isolates the teeth being treated. It enables us to do a better job of restoring your child's teeth and protects your child from exposure to the materials used in that process.

Fluoride treatment: may be used based on the child's dental history and past exposure to other fluorides.

Extractions: Removal of teeth.

Composite fillings: tooth colored resin fillings.

Stainless steel crowns: used when the tooth is too badly decayed to hold a filling.

Sealants: a thin coating of resin is placed on the biting surfaces of the teeth to prevent decay from starting. The teeth must be cleaned and etched with a mild acid before the sealant is placed. Occasionally some decay is discovered. This requires the placement of a preventative resin restoration, for which a separate fee is charged.

Protective stabilization and gentle restraint: used only when necessary to protect your child and/or the dental team.

Please sign below if you agree to the following statements:

- I am informed that in most cases if I fail to keep an appointment without giving the office 24-hour notice, I will not be granted priority rescheduling.
- I am advised that although good treatment results are expected, there can be no guarantee expressed or implied as to the result of treatment or cure.
- I understand that, although adverse reactions to routine dental care are rare, they can occur. Adverse reactions may include nausea, vomiting, dizziness, breathing difficulty, allergic reactions, excess bleeding, and prolonged numbness. I understand that any of these adverse reactions may require hospitalization and could lead to death.

I authorize Dentistry for Kids to take the radiographs (x-ray films) necessary to provide dental care and expect to be informed before any radiographs are taken. If I do not agree to radiographs, a separate form will be provided, releasing the doctors from certain liabilities.

Signed _____ **Date** _____

FINANCIAL POLICY
DENTISTRY FOR KIDS

Your child's dental care is our primary objective. Our professional relationship depends on your clear understanding of our financial policy as well as of your own insurance plan, if applicable.

Payment is due at time of service. *If you have dental insurance*, as a courtesy to you, we will submit your claims. Since our patients represent over 350 insurance companies, we can't be experts on everybody's policy. It is your responsibility to be familiar with your own policy. If you have questions or confusion, please call your insurance company directly so that there are no surprises.

We have contracts with Dental Source, United Concordia, most Delta Dental plans, Cigna, Dental Network of America, and all forms of Medicaid. For other insurance companies we ask you to pay 25% of the day's services as well as gross receipts tax, after your appointment. This will be an estimate. We will then bill your insurance and if the insurance company pays out more than expected we will reimburse you. If the insurance company pays less, then we will send you a statement for the remaining balance.

Once we send out a claim, insurance companies are required by law to make a determination on it within 45 days of receiving it. You will then be notified of any balance that is due. We expect payment of that balance within 30 days of notification. Your dental insurance is a contract between you and your insurance company, not this office. We will not become involved in disputes between you and your insurance company other than to supply factual information as needed.

This office will not become involved in marital or family disputes. The person designated as the responsible party — the one making appointments and bringing the patient to appointments — will be sent all relevant communications including bills. That individual is responsible for the payment of bills. This person will also receive our phone calls and notices of payment due, regardless of court settlements or personal arrangements.

If someone other than a parent brings a child into an appointment, we need to have a signed parental consent form authorizing this office to treat the child before the child can be seen.

We accept the following forms of payment: cash, checks, all major credit cards as well as the Care Credit health care credit card. If you have questions about applying for Care Credit, please see our front desk staff.

Other Service Charges:
*18% Annual (1.5% monthly) interest is charged to accounts with outstanding balances 60 days from date of service.
*Returned checks are subject to a $25 service charge.

I have read this policy statement and hereby agree to the conditions herein:

Signature: _____ **Date** _____

ATTENDANCE POLICY
DENTISTRY FOR KIDS

Here at Dentistry for Kids we try our very best to keep our schedule running on time, and you as the patients can help us by arriving a few minutes early for your appointment.

When patients are even slightly late it can throw off our schedule for the whole day.

So, if you are five minutes late, we MAY have to reschedule your appointment. We will do our best to see you, but we must prioritize other patients who are on time that day. If you are ten minutes late or more, we will try to find a later opening on the schedule for you that day, or if the schedule is full, we will gladly help you reschedule for another day.

We do our best to see each and every patient, so let us know if something unexpected comes up and we will do what we can to accommodate you.

We totally get that life happens! Communicate with us and we'll do our best to take care of you!

I have read and understand the Dentistry for Kids attendance policy.

Print Name: _____ **Date** _____

Signature: _____ **Date** _____

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Patient Name:_____Date of Birth:_____

Parent Name: _____Phone number:_____

- Do you have concerns with your child's ability to understand or communicate?
  ☐Yes☐No
- Do you have a hard time getting your child to eat a variety of foods?
  ☐Yes☐No
- Does your child have difficulty sitting still?☐Yes ☐No
- Does your child have difficulty paying attention or following directions?
  ☐Yes☐No
- Has your child been diagnosed with Autism?☐Yes☐No
- Has your child been diagnosed with ADD/ADHD? ☐Yes ☐No
- Does your child have any balance or coordination concerns?☐Yes ☐No
- Any difficulty with sitting up, crawling, walking or rolling?☐Yes ☐No

Dentistry for Kids (DFK) prides itself in a holistic approach to treating children. We partner with other providers to help your child be most successful.

By signing below you are giving permission for DFK to share this information with our partnered agencies to better assist your child. They may contact you to offer their assistance.

_____

Parent/Guardian Signature Date

Dentistry for Kids delivers dental care in a compassionate individualized way, promoting and restoring ideal oral form and function to New Mexico's children. We are educated, responsible, available and consistent in our services. Our emphasis is on preventative care and the links between oral health and overall health. All of our locations deliver the same excellent dental care.