Date_____

Just for Kids Pediatric Dentistry, Ltd.
Patient Information

Child's Name_____ Age_____ Date of Birth_____

Parents' Names_____

Address_____ City_____ Zip_____

Parent's Marital Satus (M)_____ (S)_____ (D)_____ With whom do the children reside? _____

Telephone: Residence_____ Father Work/Cell_____

Email Address_____ Mother's Work/Cell_____

With whom may we discuss child's treatment? (Check all that apply) AND SIGN BELOW

_____Parent(s) _____Custodial parent only _____Childcare person

_____Other family member/friend_____
Name/relationship

_____
Signature

Father Employed By_____How Long_____

Mother Employed By_____How Long_____

Referred By (or how did you hear about our office)_____

Dental Insurance: **If you have dental insurance please complete the New Patient Dental Insurance Information form**.

Parent's Social Security Numbers: Father_____

Mother_____

Parent's Driver's License Numbers: Father_____

Mother_____

Nearest Relative_____ Relationship to Child_____

Phone Number(s)_____

Please answer all questions. If there are any questions that you do not understand, please ask, we will be happy to assist you. All information is held in the strictest of confidence. Thank you for providing us with this information.

Child's Name_____ Date_____

Dental History

Why are you bringing your child to the dentist?_____
Has your child ever been to the dentist? ___Yes ___No If yes, date of last dental visit_____
If yes, how was your child's past dental experience? ___Positive ___Negative
Has your child ever experienced an adverse reaction during or in conjunction with a medical or dental procedure?

___Yes ___No If yes, please explain_____

How often does your child brush?_____ Floss?_____ Do you assist?_____

Briefly describe any past dental trauma_____
Circle Y or N if your child has had any of the following:

Y/N Bad breath	Y/N Sensitivity to cold/hot	Y/N Loose teeth or broken fillings
Y/N Bleeding gums	Y/N Sensitivity when biting	Y/N Food collection between teeth
Y/N Grinding or clenching teeth	Y/N Sensitivity to sweets	Y/N Sores or growth in mouth
Y/N Clicking or popping jaw	Y/N Finger, thumb or pacifier habit	Y/N Fluoride supplements

Medical History

Name of child's physician_____ Pnone #_____
Date of last visit_____ Is your child's immunization up to date ?___Yes ___No

Is your child presently under medical care? Y/N If yes, explain_____

Is your child currently taking medications? Y/N If yes, reason_____

Medications presently being taken_____
Has your child ever been hospitalized or put to sleep for an operation? Y/N If yes, please list dates & procedures:

_____

Has child's physician ever recommended antibiotics for dental treatment? Y/N If yes, reason_____

Does your child see a specialist? Y/N If yes, reason_____

Does your child have or has child ever had allergies or reactions? Y/N If yes (please circle all that apply):
Penicillin Erythromycin Sulfa Anesthetics Latex Foods (list)_____
Other_____
Circle Y or N if your child has had any of the following medical problems

Y/N Heart disease	Y/N Abnormal bleeding from a cut	Y/N Asthma/breathing problems
Y/N Heart murmur	Y/N Frequent nose bleeds	Y/N Seizures/Epilepsy
Y/N Congenital heart defect	Y/N Unexplained bruising	Y/N Diabetes
Y/N Rheumatic Fever	Y/N Hemophilia/bleeding disorder	Y/N Hepatitis
y/N Mononucleosis (Mono)	y/N Anemia	Y/N HIV+/AIDS
Y/N Bone problems	y/N Blood transfusions	Y/N Cancer

Other Medical Conditions_____
Characterize your child's mental development. ___Normal ___1-2 years behind ___More than 2 years behind
Has your child been diagnosed with: Autism Y/N Aspergers Syndrome Y/N ADHD Y/N
Other developmental conditions Y/N If yes, please explain_____
I understand the information given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my child's medical condition.

Signature of parent or guardian_____ Date_____

Just For Kids Pediatric Dentistry, Ltd.

New Patient Dental Insurance Information

Patient Last Name _____ First Name _____

Middle Name _____ Nickname _____

Home Address _____

Home Phone _____ DOB _____ Sex: M/F

Medical Alerts _____

Primary Dental Insurance Coverage

Subscriber's Full Name _____

Relationship to Patient _____ SS# _____ DOB _____

Employer's Name _____ Group # _____

Insurance Company Name and Address _____

_____

Secondary Dental Insurance Coverage

Subscriber's Full Name _____

Relationship to Patient _____ SS# _____ DOB _____

Employer's Name _____ Group # _____

Insurance Company Name and Address _____

_____

Parent/Guardian Responsible for Patient

Name _____

Signature Date

JUST FOR KIDS PEDIATRIC DENTISTRY, LTD.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, _____, (PLEASE PRINT NAME OF PARENT/GUARDIAN) have received a copy of this office's Notice of Privacy Practices for the following:.

_____
{Please Print Child(ren)'s Name(s)}

_____
{Signature}

_____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____

_____

_____

JUST FOR KIDS PEDIATRIC DENTISTRY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY
We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect April 14, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION
We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $15.00 per set of records for staff time to locate, copy, and mail your health information. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. **{You must make your request in writing.}** Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

Contact Officer: Kathleen Geraci, Office Manager

Telephone: 630.961.0996 Fax: 630.579.0850

Address: 1220 Hobson Rd, Ste 224, Naperville IL 60540-8138

Welcome to Just for Kids Pediatric Dentistry, Ltd.!

Consent for dental examinations for _____.

Thank you for choosing us as your child's dentist. We are committed to your child's successful treatment. Please understand that prompt payment of the account is considered a part of your child's treatment. The following is a statement of our policies.

OFFICE VISITS

Payment for the initial examination is due at the time of service. Payment for all other visits is due at the time of service unless prior arrangements have been made (see Insurance below).

All children will be brought back to visit with the dentist by themselves. Only for extremely young patients or for patients with severe disabilities will an exception be made to this policy.

The initial visit is spent conducting a thorough examination. We need to know important medical facts about your child and ask that you complete the medical history as accurately as possible. Depending on your child's age, several x-rays will be taken to determine the presence of cavities between the teeth and the number and location of permanent teeth. We will examine, clean and apply flouride to the teeth. We will then discuss the findings with you. IF YOU DO NOT WANT FLUORIDE OR X-RAYS, PLEASE LET US KNOW BEFORE YOUR CHILD IS TAKEN TO THE EXAMINATION ROOM

Recall examinations will be conducted in a similar manner. However, if your child maintains ZCG (zero cavity growth) for one full year, we will recommend that diagnostic x-rays be taken on an annual basis rather than at each six-month recall examination. IT IS IMPERATIVE THAT ALL CHANGES TO YOUR CHILD'S MEDICAL HISTORY BE BROUGHT TO OUR ATTENTION BEFORE YOUR CHILD IS TAKEN BACK TO SEE THE DENTIST.

INSURANCE

We may accept assignment of insurance benefits after your second visit. However, we may require 20% of all restorative charges, 50% of orthodontic appliances and crowns **to be paid at the time of service**. The balance is your responsibility whether your insurance company pays in part or in full. If there are any changes to the insurance information we have on file, let us know when you are checking your child in. Your insurance coverage is a contract between you and your insurance company. Since we are not a party to that contract, we ask that you keep in contact with your insurance company to check status of outstanding claims. If your insurance company does not make payments to out-of-network providers, payment is due at the time of services. **Your signature on this document gives permission for insurance benefits to be assigned to the dentist.**

If your account carries a balance after 45 days (regardless of whether insurance has made payment), a billing charge of $1.50 will accrue monthly ***with no exceptions***. An alternative to the monthly billing charge is to set up a "cash" account (we accept cash, check, Visa, Discover, or Mastercard). We can then supply you with the necessary paperwork for you to submit a claim to your insurance company. Any balance automatically becomes your responsibility in full after 4 months if insurance has not paid the claims submitted.

MISSED APPOINTMENTS

Unless an appointment is canceled at least 24 hours before an appointment time, we reserve the right to charge an amount of $50.00 for that canceled/missed appointment. If three appointments are missed during peak, non-school hours, we reserve the right to schedule appointments for your child only during non-peak hours.

MONTHLY BILLING CHARGE

If any portion of your account remains unpaid, a monthly billing charge of $1.50 per month will be added to the account after 45 days ***with no exceptions***. This policy applies whether we are waiting for your insurance to pay or whether you have no insurance.

OTHER CHARGES (Subject to change without notice)

Duplication of Records: $15.00 per child
Returned Check: $35.00

Thank you for reading and understanding our financial policy. Please let us know if you have any questions or concerns.

I have read the above information and understand and agree to the contents of this document

_____ _____

SIGNATURE RELATIONSHIP TO CHILD

_____

DATE