Kids Dental Center, LLC

410.465.6000
Daniel E. Biederman, DDS 410.740.0606

Patient Name: _____
Birthdate: _____

General Information

Father's Name: _____
Date of Birth: _____
Work Phone #: _____
Cell Phone #: _____
Employer: _____
SS #:_____
Address (If different from patient)
_____
_____

Mother's Name: _____
Date of Birth: _____
Work Phone #: _____
Cell Phone #: _____
Employer: _____
SS #: _____
Address (if different from patient)
_____
_____

Patient Address: _____ City_____ State _____ Zip_____
Patient SS#: _____ Phone (Home) #: _____

Emergency Contact
Name: _____ Relationship: _____
Phone (H): _____ Phone (Cell):_____
Name of School: _____
Favorite Subject: _____ Game: _____
Story: _____ TV Program: _____

Insurance Assignment

Name of 1st Insurance Carrier: _____
Policy # / Group #: _____
Subscriber's Name: _____
Subscriber's date of birth: _____
Subscriber's SS#: _____
Employer: _____
Insurance Address: _____
Insurance Phone #: _____

Name of 2nd Insurance Carrier:_____
Policy # / Group #: _____
Subscriber's Name:_____
Subscriber's date of birth: _____
Subscriber's SS# _____
Employer: _____
Insurance Address: _____
Insurance Phone #: _____

I do hereby request that the above named carrier(s) pays the benefits due me in my pending claim for services on my dependent child(ren) directly to:

Kids Dental Center, LLC
Daniel Biederman, DDS
5060 Dorsey Hall Drive, Suite 104
Ellicott City, MD 21042-7711

Financially responsible person (if different than parent): _____

Subscriber's Signature: _____
Subscriber's Printed Name: _____ Date _____

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Patient Name: _____
Birthdate: _____

Health History

Date: _____ □ Male □ Female Does the patient speak English? □ Y □ N

1. Was the pregnancy full term? □ Yes □ No
2. Is your child in good health? □ Yes □ No
3. Has the child ever received a blood transfusion? □ No □ Yes
4. Are all immunizations updated? □ No □ Yes
5. Has the child ever been hospitalized or had surgery? □ No □ Yes
6. Has the child received any tubes, shunts, or prostheses? □ No □ Yes
7. Does the child receive routine medical exams? □ No □ Yes
8. Date of last medical exam: _____

Has the child ever been diagnosed with any of the following conditions?

9. HIV / AIDS, exposure	Yes / No	18. Allergy to latex	Yes / No	27. ADHD, behavioral disorder	Yes / No
10. Hepatitis, liver dis.	Yes / No	19. Allergy to foods	Yes / No	28. Mental retardation, func age	Yes / No
11. Cancer	Yes / No	20. Allergy to Medication	Yes / No	29. Cerebral Palsy	Yes / No
12. Epilepsy, seizures	Yes / No	21. Special Diet	Yes / No	30. Learning disorder	Yes / No
13. Kidney disorder	Yes / No	22. Asthma	Yes / No	31. Emotional disorder	Yes / No
14. Venereal disease	Yes / No	23. Measles, Chicken Pox	Yes / No	32. Motor skills disorder	Yes / No
15. Pregnancy	Yes / No	24. Diabetes	Yes / No	33. Speech disorder	Yes / No
16. Tuberculosis, expos	Yes / No	25. Lung condition	Yes / No	34. Hearing loss	Yes / No
17. Skin Rash	Yes / No	26. Autism	Yes / No	35. Vision disorder	Yes / No

36. Take any medicines or Vitamins? □ No □ Yes
37. Blood disorder, anemia, sickle cell anemia / trait, hemophilia, other : □ No □ Yes
38. Heart disease, murmur, congenital defect, history of rheumatic fever: □ No □ Yes
39. **Is there any medical condition from which the child suffers which is not listed**? □ No □ Yes

In the space provided below, please explain any box marked "Yes" for the above questions 1-39.

_____
_____
_____
_____
_____

Name of Pediatrician: _____ Phone # _____

I certify that I have read and understand the above. I acknowledge that my questions, if any, about the inquiries set forth above have been answered to my satisfaction. I will not hold KDC, my dentist, or any member of his/her staff, responsible for any errors or omissions that I may have made in the completion of this form.

Name of person completing this form: _____
Relationship to patient: □ Mother □ Father □ Other _____

Parent/guardian signature: _____ Date: _____
Print Name: _____

Signature of Dentist / hygienist: _____ Date: _____

Note: Any change to the health status of the above patient should be reported to the office as soon as possible.

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Consent for Treatment and Payment Agreement

Authorization for Care & Treatment: I hereby authorize and agree that Kids Dental Center, LLC (KDC) may perform dental care and dental treatment, and may conduct such examinations, laboratory tests and procedures, diagnostic tests and procedures, administer such local anesthetics, medications and treatment, as may be directed by the dentist and staff of KDC attending to my child. I acknowledge that no guarantees have been made to me as to the effect of such examinations, tests, procedures or treatment of my child's condition.

Authorization to release Medical Information: I hereby agree that my child's attending dentist may furnish medical information maintained by KDC in the course of my child's care and treatment to my child's primary care physician and to any entity that is involved in my child's care and treatment. Release of medical records and information will be made according to state and federal regulations. I further consent that KDC may release medical information to any third party, including my employer, which may be responsible for payment of my child's dental or medical expenses. [Release of medical and dental information to employers is limited to those employers who are directly liable for the costs of the patient's health care benefits through employer self-insured worker's compensation, or in other circumstances in which such release is legally allowed.]

Insurance Authorization: I understand that I am responsible for knowing the terms and conditions of my insurance coverage. I further understand that I may be responsible for obtaining prior authorization for certain services in order for my insurance company to pay for those services and I understand that I may be personally responsible for payment if I do not obtain any necessary prior authorization or my insurance benefits are denied, reduced, or terminated. [In accordance with federal law, KDC will not deny or delay necessary emergency dental care or emergency dental treatment, for active patients of record, because of a person's inability to pay for such necessary emergency dental treatment.]

Assignment of Benefits, Insurance proceeds, settlements: If my child is entitled to health care services under any insurance policy from any person or organization which may become liable to me to provide such benefits, I assign such benefits to the KDC and dentists and staff employed by KDC who render such services to my child. I further authorize payment directly to KDC of all such insurance benefits payable to me. Such insurance may include, but is not limited to, private commercial insurance, auto liability insurance, workers compensation, programs such as Medicare and Medicaid, or other governmental sources. I certify that the information given regarding my insurance is accurate and current to the best of my knowledge. I further assign to KDC any payments for dental benefits payable to me as a result of any settlement or judgment in a lawsuit.

Financial Agreement: **Payment for services is due on the same date treatment is rendered**. In consideration for services rendered by KDC and dentists and staff employed by KDC, I guarantee prompt payment for all such services not paid by insurance carriers or third parties within thirty (30) days of dental treatment rendered. I understand that any amounts not covered by my insurance carrier or other third party payor are my personal responsibility, and I agree to make payment for any such amounts. Any balances that remain unpaid more than thirty (30) days following the date of dental services rendered are subject to a 1 ½ % per month (18% per year) finance charge (minimum charge is $3.00). Return checks are subject to a $35.00 returned check fee. If KDC does not receive such payment within thirty (30) days from the date such balance is due, the bill may be turned over to an attorney or a collection agency and, if so, I agree to pay all reasonable collection costs including attorney's fees, court fees, and/or collection fees in addition to the payments owed. I give KDC the right to examine my consumer credit report for financial information relating to my responsibility to pay for dental services. I understand that Dentists and staff of KDC are not employed by Howard County General Hospital, and if dental treatment is rendered utilizing such facilities, I will receive a separate bill from these facilities and their independent contractors that are utilized for their services. If for any reason I am unable to make payment, I will immediately contact the KDC financial manager and set up reasonable financial arrangements.

Release of Liability for Valuables: I understand and agree that KDC shall not be liable for loss or damage to any personal property.

Telephone: Use of cellular phones, including photographs and videos is strictly prohibited while inside the KDC office.

Missed Appointment Fees: When you call to schedule a dental appointment for your child, the Kids Dental Center reserves room space, and staffs that room. As such, if your child does not show up for their appointment, the staff and room space are unable to by utilized by another patient. Therefore, we do require minimally 24 hours advanced notice to cancel or reschedule your appointment, with the exception of an emergency or unforeseen event, else a missed appointment fee of $45 per 30 minute time slot is applied. We will gladly re-schedule this missed appointment as soon as the applicable fee is paid.

Patient Name _____ Date of Birth _____
Parent/Guardian Signature_____Date_____
Interpreter (if used) Signature _____Date _____

Note: If the individual signing is the Health Care Agent or Guardian, written documentation must be provided to authorize his/her legal authority to consent. A copy of the documentation must be placed in the patient's dental record.

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Patient Name: _____
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Dental History

What is your primary dental concern regarding your child's teeth? _____
Does your child have any toothaches? Yes / No
Does your child have any brothers or sisters? Yes / No _____

Is this your child's first dentist visit? Yes / No

Name and location of previous dentist: _____
_____

Did either your child or you experience any difficulties at the previous dentist? Yes / No
Please explain:_____
_____

Has your child had:

Fillings:	Yes / No	Orthodontic treatment	Yes / No
Crowns	Yes / No	TMJ problems	Yes / No
Extractions	Yes / No	Headaches	Yes / No
Nitrous Oxide Gas	Yes / No	Grinding / clenching	Yes / No
Fluoride	Yes / No	Traumatic injury to teeth	Yes / No
X-rays	Yes / No	Extra or missing teeth	Yes / No

Is there any family history of gum disease, missing or extra teeth, orthodontic care, extensive fillings, TMJ problems, or excessive fear of the dentist? Yes / No
Please explain: _____
_____

Does your child fear medical / dental visits? Yes / No (mild) 1 2 3 4 5 (severe)

Do you have any fear of medical / dental visits? Yes / No (mild) 1 2 3 4 5 (severe)

Referred by: Phone book
Newspaper advertisement
Pediatrician: _____
Friend: _____
Other: _____