



PATIENT REGISTRATION AND MEDICAL HISTORY

Welcome to Kidz-R-Kool Pediatric Dentistry. We would like to welcome you and your child to our dental office. Our primary goal is to make every visit fun & educational. Our practice is based on preventive dental care. We strive to teach good oral care that will enable your child to maintain a beautiful smile for a lifetime!

ABOUT YOUR CHILD:

Child's Name _____ Nickname _____

Date of Birth _____ Male Female

Home Address _____ Home Phone _____

City _____ State _____ Zip Code _____

How did you hear about our office?

Friend _____ Dr Referral Paper Yellow Pages Internet Other _____

PARENTS/LEGAL GUARDIANS INFORMATION:

MOTHER'S INFORMATION

EMAIL ADDRESS _____

Name _____ Date of Birth _____ Marital Status _____

Address _____ Social Security _____

City, State, Zip _____ Employer _____

Home Phone _____ Cell Phone _____ Work Phone _____

FATHER'S INFORMATION

EMAIL ADDRESS _____

Name _____ Date of Birth _____ Marital Status _____

Address _____ Social Security _____

City, State, Zip _____ Employer _____

Home Phone _____ Cell Phone _____ Work Phone _____

EMERGENCY INFORMATION:

In case of an emergency whether neither parent nor legal guardian can be reached, please identify the following information for the next closest relative **NOT** living with the patient.

Name _____ Relation _____ Phone _____

Address, City, St, Zip _____

KIDZ - R - KOOL * 7505 W DEER VALLEY RD #110, PEORIA, AZ 85382, (623)572-5777



DENTAL INSURANCE INFORMATION

CHILD'S NAME _____

Primary Insurance Co Name _____ Phone Number _____

Primary Insured _____ ID# _____

Date of Birth of Primary Insured _____ Group # _____

Employer of Primary Insured _____

Secondary Insurance Co Name _____ Phone Number _____

Primary Insured _____ ID# _____

Date of Birth of Primary Insured _____ Group # _____

Employer of Primary Insured _____

MEDICAL/DENTAL RELEASE STATEMENT:

I give my consent for the doctor of Kidz-R-Kool Pediatric Dentistry to do a complete and thorough examination on the patient named above, including any diagnostic radiographs needed. To the best of my knowledge, the information that I have given is correct and I understand that it will be held in the strictest of confidence. Furthermore, I understand that it is my responsibility to inform Kidz-R-Kool Pediatric Dentistry of any future changes to my child's medical or dental status. As the parent or legal guardian of the patient named above, I do hereby grant Dr. Richard Brenke and his staff permission to perform any needed treatment(s). I also understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time of service, unless prior arrangements have been approved. _____ (initial)

REQUIREMENT FOR FILING INSURANCE CLAIMS. To expedite the filing of my dental insurance claims, I do hereby authorize the release of confidential information to my dental insurance agency and understand that I am personally responsible for any balance remaining after the insurance payment has been received. I am also fully responsible if my insurance policy fails to pay, for any reason, within thirty (30) days of treatment. I hereby authorize payment of insurance benefits directly to Kidz-R-Kool Pediatric Dentistry or the dentist that performs treatment on my child. Furthermore, in the event of payment default for services preciously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount. _____ (initial)

Parent or Legal Guardian Signature _____ Date _____

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LEGAL CONSENT TO MAKE DECISIONS

CHILD'S NAME _____

As a convenience, we would like to offer you a chance to provide Kidz-R-Kool, Dr. Richard Brenke and his staff, with a list of individual(s) that may accompany your child to subsequent visits. Listing an individual will automatically provide them with your legal consent to make both treatment and financial decisions on your behalf.

With this list, a family member, step-parent, or good friend would have the authority to accompany your child to the dental appointment and make decisions without the need of any additional written or oral consent. If not listed, patients must always be present with a parent or legal guardian. Please only provide the names of those individuals that you trust to make sure decisions as treatment changes, to make payments, and to discuss medical and financial information. Please remember, individuals that are permitted to make treatment decision will also be responsible for any incurred payment changes.

We, as a HIPAA compliant healthcare facility, will use our best discretion to maintain all personal information and will only provide the individuals listed below with information needed to make a specific decision on your behalf. Information will only be provided on a need-to-know basis and we will not allow these individuals to have or copy your child's dental chart. We simply want to make treating your child in our facility as convenient as possible for you.

Please identify such individuals with your signature at the bottom of this form with your decision to allow them to provide consent to make treatment decisions, to make financial arrangements, or both. Please also remember any individuals accompanying your child to an appointment will also be responsible for additional charges incurred during that particular visit.

CONSENT TO MAKE DECISIONS:

Individual's Name

Relationship

As the parent or legal guardian of the patient notes above, I do hereby provide the individuals listed beneath the CONSENT TO MAKE DECISIONS, the legal authority to make decisions in my absence. I also understand that these decisions may change or alter previous treatment recommendations or charges that I have already agreed to and that I as this child's parent or legal guardian, am ultimately responsible for any new charges incurred as a result of treatment decisions made by any individual listed above.

Parent or Legal Guardian Signature _____ Date _____

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CONSENT STATEMENTS

CHILD'S NAME _____

The following consent statements refer to documents containing information regarding specific policies of Kidz-R-Kool Pediatric Dentistry. Please sign these statements only after carefully reading such information. These informative documents should be retained for future reference.

FINANCIAL & INSURANCE INFORMATION

I have read the form entitled, "Financial & Insurance Information" including details regarding my financial responsibility towards care rendered by doctors at Kidz-R-Kool Pediatric Dentistry and understand that the parent or legal guardian who accompanies my child to an appointment will be responsible for payment at the time services are rendered, unless prior arrangement have been made.

Parent or Legal Guardian Signature _____ Date _____

CANCELLATION POLICY

I have read the form entitled, "Cancellation Policy" and understand its contents. Furthermore, I take full responsibility for the cancellation of any needed appointments and am aware that without prior notification or a valid reason, a \$25 fee will be incurred.

Parent or Legal Guardian Signature _____ Date _____

NOTICE OF PRIVACY PRACTICES

Health Insurance Portability & Accountability Act of 1996

I have read the form entitled, "Notice of Privacy Practices" and understand its contents concerning the privacy of my child's confidential healthcare information. I do hereby provide consent for the standard use of such information and understand that these provisions prohibit Kidz-R-Kool Pediatric Dentistry from selling or transferring this information to any unauthorized location without my prior approval. I have reviewed this information and all questions have been answered to my satisfaction.

Parent or Legal Guardian Signature _____ Date _____

FOR OFFICE USE ONLY

I attest that the following documents were provided to the parent or legal guardian of the child noted above. All questions have been answered and I have witnessed the signing of these consent statements.

Witness Signature _____ Date _____

KIDZ-R-KOOL

NOTICE OF PRIVACY PRACTICES

Health Insurance Portability & Accountability Act of 1996

Federal & state laws require Kidz-R-Kool Pediatric Dentistry to maintain the privacy of all patient healthcare information. Furthermore, we are required by law to provide all parents or legal guardians with this notice reviewing our privacy practices, our legal obligations and your rights in regards to your child's healthcare information Kidz-R-Kool must follow the privacy practices as describe within this notice while this policy is in effect. This notice takes effect on April 14, 2003 and will remain in effect until replaced, amended or eliminated.

Kidz-R-Kool reserves the right to change these privacy practices and the terms of this notice at any time, provided such applicable laws permit such changes. We reserve the right to make any needed changes to our privacy practices and these new terms will be effective for all health information that we maintain, including health information we create or receive before such made changes. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available upon request.

Parents or legal guardians may request a copy of this notice, at any time. For additional information about our privacy practices or to review our company's Health Insurance Portability & Accountability Act (HIPPA) Manual, please contact us at any of our locations.

USES & DISCLOSURES OF HEALTHCARE INFORMATION

Kidz-R-Kool Pediatric Dentistry will use and disclose patient healthcare information during your child's treatment, while obtaining payment from insurance companies and during general healthcare operations. For example:

Treatment: Kidz-R-Kool may use your child's health information during his/her direct treatment or by disclosing such information to other dentists, physicians or health care providers who may provide specialized treatment for your child.

Payment. We may also use and disclose your child's health information to obtain payment for services rendered. We may disclose your child's healthcare information to another healthcare provider or entity that is also subject to these same federal & state Privacy Rules & Regulations for payment activities.

Healthcare Operations. We may use and disclose your child's healthcare information during our routine healthcare operations. Healthcare operations may include quality assessments and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, and certification, licensing or credentialing activities. We may disclose your child's healthcare information to another healthcare provider or organization that is subject to the same federal & state Privacy Rules & Regulations and that has a relationship with you during the support of health care operations. We may disclose your child's information to help such organizations conduct quality assessment and improvement activities, review the competence or qualifications of healthcare professionals or detect or prevent healthcare fraud and abuse.

On Your Authorization You may give Kidz-R-Kool written authorization to use your healthcare 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 uses or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your child's healthcare information for any reason except those described within this notice.

To Your Family & Friends. We may disclose your child's health information to a family member, friend or other person to the extent necessary to help with your child's healthcare or with payment for previously performed healthcare services. Before we disclose your child's health information to these people, we will provide you with an opportunity to object to our use or disclosure. If you are not present, or in the event you are incapacitated and cannot make a decision for your child, or in the event of an emergency, we will disclose your child's medical information based on our professional judgment of whether the disclosure would be appropriate and in your child's best interest. We will use our professional judgment and our experience with common practices to make reasonable inferences of your child's best interest in allowing a person to pick up filled prescriptions, medical/dental supplies, radiographs, or other similar forms including health information. We may also use or disclose information about your child to notify or assist in notifying a person involved in his/her care.

Appointment Reminders. Kidz-R-Kool may use or disclose your child's healthcare information to provide you and your family with appointment reminders (such as telephone calls, voice messages, postcards, or letters).

Disaster Relief. We may use or disclose your child's healthcare information to a public or private entity authorized by law or by its charter to assist in federal or state disaster relief efforts.

Public Benefit. We may disclose your child's medical/dental information, as authorized by federal or state law for the following purposes deemed to be in the public's best interest or benefit:

- As required by law.
- For public health activities, including disease and vital statistic reporting, reporting child abuse or neglect, FDA oversight, and to employers regarding work-related illness or injury.
- To health oversight agencies.
- In response to court and administrative orders and other lawful processes.



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FINANCIAL & INSURANCE INFORMATION

We appreciate you allowing us to provide dental care for your child as one of the Valley's leading providers for pediatric dental care, we wish to attract parents that take an active role in their child's dental health and remain financially responsible. Because we value our relationship with you and believe that the best relationships are based upon understanding, we offer these clarifications on methods of payment & insurance reimbursements.

Upon your first visit, we will request a copy of your dental insurance information to allow us to file your claim for this and all future visits. Please remember to bring all dental insurance information, as well as insurance card(s). We also ask that you contact us immediately after making any changes to your dental coverage, so we can keep our records current and to provide expeditious reimbursement of your benefits.

Dental Insurance. We are dedicated to providing all our patients with the finest treatment available and base our treatment recommendations on what will be best for your child and not what your insurance company does or doesn't pay. Please note the following in regards to your dental insurance coverage:

1. We must emphasize that as a health care provider, our relationship is with you and not your dental insurance company. Your dental insurance is a contract between your employer and the insurance company. Most plans routinely pay between 50-75% of the average total fee for a given procedure. This percentage is determined by how much your employer has paid for coverage.
2. As a courtesy, we will be happy to file for your insurance benefits, though we are not obligated to do so. Because your dental insurance plan is a contract between you, your employer, and the insurance company, many carriers will not reimburse our office. In this instance, you will be responsible for the full cost of each visit at the time services are provided and your insurance company will send you're the reimbursement check, directly.
3. Any amount not covered by your insurance company is payable at the time services are rendered; these fees may include deductibles, co-payments, or certain procedures not covered by your insurance policy. Unfortunately, some of the services that we may recommend for your child will not be covered by your specific dental insurance. Our primary goal is to treat your child using the best possible materials, supplies, medications and environment and not necessarily in the cheapest manner, which is sometimes the goal of many insurance companies.
4. We allow a maximum of 45-days for your insurance company to clear account balances. Any unpaid portions will be due in full, by you, after this period.
5. Our office does not determine your dental benefits. Your employer chooses your particular policy and if you are unhappy with its coverage, this should be mentioned to your superior. Only your employer can adjust benefits.

Methods of Payment. For your convenience we accept personal checks and major credit cards (Visa, MasterCard, Discover, & American Express). All returned personal checks will be assessed a \$35 management fee.

Financing Programs. To help provide cost-effective care to our patients, we accept Care Credit. You can apply and inquire about this program by going to www.CareCredit.com.

Financial Obligation. After attempts to collect outstanding funds and a 90-day grace period from time of service, parents/guardians not fulfilling their financial obligation will be sent to collections, as stipulated by our accountants.

We will always do our best to maximize the insurance benefits that you are eligible to receive and we appreciate your prompt settlement of any charges that may be incurred during the treatment process. We look forward to years of close association with you, as we work together to maintain your child's oral health!

Prior to completing any treatment, we will provide you with a cost estimate indicating our total fee, what we anticipate your insurance coverage to be, and your estimated out of pocket portion. Please remember, this is only an estimate based upon generalized information provided by your policy. An additional billing or possibly a refund may be subsequently required should these estimates be inaccurate.

I have read the following details regarding my financial responsibility towards care rendered at *Kidz-R-Kool Pediatric Dentistry* and understand that the parent or guardian who accompanies my child is responsible for payment at the time of services, unless prior arrangements have been made.



CANCELLATION POLICY

Kidz-R-Kool Pediatric Dentistry makes every effort to see patients in a timely fashion. Because we are limited to the number of patients we are able to treat during any given period of time, our schedule quickly becomes full. In an effort to provide all our patients with timely care, we ask that you have the courtesy to honor our 24-hour cancellation policy. This, in turn, will allow us to provide treatment for another patient in great need.

Kidz-R-Kool Pediatric Dentistry also reserves the right to charge patients a \$25 NO SHOW fee for any appointment broken without prior notification.

In order to confirm your presence, we will routinely contact you the day prior to any scheduled appointments. If needed, please take this opportunity to let us know if you will not be able to make this visit so we have time to rearrange our busy schedule.

Thank you for your understanding and as always, *Kidz-R-Kool Pediatric Dentistry* intends to attract parents that share a common interest in providing their children with the best possible dental care available, that remain responsible, and take an active role in their child's long term dental success.

I have read the cancellation policy and understand its contents. Furthermore, I take full responsibility for the cancellation of any needed appointments and am aware that without prior notification or a valid reason, a \$25 fee will be incurred.