760.745.7070
info@kidzcaredental.com
www.kidzcaredental.com
625 W. Citracado Pkwy, Suite #208
Escondido, CA, 92025

New Patient Dental & Medical History Form

We are pleased to welcome you to our practice. Please complete this form. The following information is necessary to enable us to provide your child with the best dental care possible. All information disclosed is confidential and shall only be used for dental and medical purposes.

Patient's Name: _____
Last First MI Preferred Name

Address: _____
Street Apt# City State Zip Code

Gender: ☐ Male ☐ Female **Age:** _____ **DOB:** _____ **SSN:** _____

Siblings(Name & DOB):

_____

_____

Father's Information:

Name: _____

DOB:_____ Driver's License#:_____

Address (if different):_____

Email:_____

Phone:_____ _____
Mobile Work

Mother's Information:

Name: _____

DOB:_____ Driver's License#:_____

Address (if different):_____

Email:_____

Phone: _____ _____
Mobile Work

Parent's Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated

Who has legal custody of the child? (If applicable) ☐ Mother ☐ Father ☐ Joint ☐ Other

Is patient a foster child? ☐ Yes ☐ No ***If yes, please provide court documents.***

In case of emergency contact: _____
(other than parent/guardian) Name Relationship Phone No.

PRIMARY INSURANCE
Name of Insured: _____

DOB: _____ SSN: _____

Employer:_____ Gp No:_____

Dental Insurance:_____

ID No:_____ Phone#:_____

SECONDARY INSURANCE
Name of Insured: _____

DOB: _____ SSN: _____

Employer:_____ Gp No:_____

Dental Insurance:_____

ID No:_____ Phone#:_____

760.745.7070
info@kidzcaredental.com
www.kidzcaredental.com
625 W. Citracado Pkwy, Suite #208
Escondido, CA, 92025

FINANCIAL RESPONSIBILITY FOR SERVICES

I hereby assign directly to Kidz Care Dental Group all dental benefits, if any, otherwise payable to me for services rendered to my child. I authorize to affix my name and validate "signature on file" to all claims and documents related to any health benefits and release any information necessary to bill my child's insurance carrier. I understand that I am financially responsible for any charges not covered by my child's insurance and that my portion is due and payable at the time services are rendered unless other arrangements have been made. I understand that any account balance over 30 days will be charged 1.5% interest per month, and/or late fees and service charges where applicable. I agree to pay all costs of collection including but not limited to court costs, commissions and costs of collection agency and reasonable attorney fees.

Signature of responsible party: _____ Date of Birth: _____

Name of responsible party: _____ SSN: _____

Relation to patient: _____ Today's date: _____

CONSENT FOR SERVICES

I am the parent, guardian, or authorized caregiver for the patient and there are no court orders now in effect that limits me from signing this consent. I understand that the information I have given is correct to the best of my knowledge, that it will be held with confidentiality. It is my responsibility to inform the dental staff of any changes in my child's health status. I hereby authorize Dr. Tahir Paul and his staff to perform any necessary dental services including but not limited to comprehensive examination, taking dental x-rays, photographs or any diagnostic aids deemed appropriate to make a thorough diagnosis of my child's dental needs, cleanings, any recommended dental treatment mutually agreed upon and the use of appropriate medication, therapy and administration of anesthetic agent indicated for such treatment.

Initial _____

I understand that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age. The dentist will provide an environment that will help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments and using variable voice tones.

Initial _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

By signing below, you consent to the use and disclosure of your child's Protected Health Information (PHI) by Dr. Tahir Paul, his staff and business associates for treatment, payment and health care operations as specified on our Notice of Privacy Practices Form. You have the right to review our Notice prior to signing this consent. The terms of this Notice may change and the revised Notice will be posted in our office. It may also be requested by contacting this office at (760)745-7070.

You have the right to request that we restrict our uses or disclosures of your child's Protected Health Information that we are otherwise permitted to make for treatment, payment and healthcare operations, although we are not required to agree to these restrictions. However, if we agree to further restrictions, they are binding to us. You may refuse to consent to the use or disclosure of your child's PHI, but a written document is required. Under this law, we have the right to refuse services should you choose to refuse to disclose your child's Protected Health Information (PHI).

I acknowledge that a copy of Notice of Privacy Practice was provided and/or received.

Signature: _____ Date: _____

Print Name: _____

760.745.7070
info@kidzcaredental.com
www.kidzcaredental.com
625 W. Citracado Pkwy, Suite #208
Escondido, CA, 92025

MEDICAL HISTORY

Child's Physician: _____ **Phone No.:** _____

Date of last Physical Exam: _____

Is your child in good health? ☐ Yes ☐ No

Has your child ever had health problems/ been hospitalized? ☐ Yes ☐ No

Please give reason and date: _____

Is your child currently taking any medications? ☐ Yes ☐ No

Please indicate: _____

Does the child follow a VEGAN diet? ☐ Yes ☐ No

Have you ever been told that your child needs to take antibiotics before dental treatment? ☐ Yes ☐ No

Has your child had any allergic reaction to: ☐ Food ☐ Latex ☐ Medication ☐ Others: _____

Specified: _____

Please check box if your child has/had any of the medical conditions yes/no?

Yes	No		Yes	No		Yes	No	
☐	☐	ADHD	☐	☐	Eating problems	☐	☐	Psychiatric Disorder
☐	☐	Anemia	☐	☐	Fainting/Headaches	☐	☐	Rheumatic Fever
☐	☐	Anxiety/Nervousness	☐	☐	Gag Reflex	☐	☐	Seizures
☐	☐	Arthritis	☐	☐	GI Disorder	☐	☐	Sleep apnea
☐	☐	Asthma	☐	☐	Growth problems	☐	☐	Sleep problems
☐	☐	Autism	☐	☐	Hearing Loss	☐	☐	Speech Problems
☐	☐	Behavior Issues	☐	☐	Heart Disease	☐	☐	Snoring
☐	☐	Bleeding (prolonged)	☐	☐	Hemophilia	☐	☐	Syndrome
☐	☐	Brain Injury	☐	☐	Hepatitis	☐	☐	Thyroid problems
☐	☐	Cancer	☐	☐	HIV Infection	☐	☐	Tuberculosis
☐	☐	Cerebral Palsy	☐	☐	Kidney Disease	☐	☐	Full term birth
☐	☐	Cleft lip/palate	☐	☐	Learning Disability	_____ How many weeks?		
☐	☐	Developmental Delay	☐	☐	Leukemia	☐	☐	Others _____
☐	☐	Diabetes	☐	☐	Neuromuscular Defect			
☐	☐	Emotional Disability	☐	☐	Orthopedic problems	_____		

760.745.7070
info@kidzcaredental.com
www.kidzcaredental.com
625 W. Citracado Pkwy, Suite #208
Escondido, CA, 92025

DENTAL HISTORY

Is this your child's first visit to the Dentist? ☐ Yes ☐ No If no, when was the last visit: _____

Name of previous Dentist: _____ Phone No: _____

Please describe your child's dental problem: _____

_____

Does your child have the following habits?

Yes	No		Yes	No		Yes	No		Yes	No	
☐	☐	Nursing bottle	☐	☐	Thumb/finger sucking	☐	☐	Pacifier sucking	☐	☐	Cheek/lip biting
☐	☐	Nail biting	☐	☐	Mouth breathing	☐	☐	Grinding of Teeth	☐	☐	Clenching of jaw

Please check if your child has any of the following:

Yes	No		Yes	No		Yes	No	
☐	☐	Cavities	☐	☐	Crowding/spacing of teeth	☐	☐	Trauma
☐	☐	Gum Infection	☐	☐	Sensitive teeth	☐	☐	Others_____
☐	☐	Toothache	☐	☐	Discolored teeth			

Please check any of the following that may describe your child's attitude towards dentistry

☐ Cooperative ☐ Friendly ☐ Anxious ☐ Shy ☐ Uncooperative

Has your child had any unhappy dental experience? ☐ Yes ☐ No

Has your child had local anesthetic (Novocaine)? ☐ Yes ☐ No
If yes, were there any problems? _____

Does your child brush his/her teeth daily? ☐ Yes ☐ No

Do you assist in brushing your child's teeth? ☐ Yes ☐ No

Does your child use dental floss? ☐ Yes ☐ No

Is fluoride taken in any form? ☐ Tablets ☐ Drops ☐ Water ☐ Paste/Gel ☐ Rinse

Does your child have sugar snacks? ☐ Yes ☐ No If yes, how often? _____
(e.g. raisins, fruit rollups, gummies, candies, gums, etc.)

How much soda and juice does your child drink? _____ times per day, _____ times per week

Is there anything else that you would like to tell us regarding your child's dental health?

_____

_____

Whom may we thank for referring you to our practice? _____
(write name of office/doctor/event, etc.)

760.745.7070
info@kidzcaredental.com
www.kidzcaredental.com
625 W. Citracado Pkwy, Suite #208
Escondido, CA, 92025

PHOTO AND VIDEO POLICY

We respect the privacy of all our patients and staff. Therefore, we do not allow photography (video or otherwise) on the premises.
Our staff is happy to assist you in capturing/documenting your children's dental visit. Please ask one of our staff members for assistance.

APPOINTMENT POLICY

Your scheduled appointment time has been reserved exclusively for your child or children. We understand that unexpected things occur in life and that circumstances may arise that make an appointment time inconvenient. However, **we do request 48 hr notice of cancellation** so that we may be able to offer that appointment time to another patient that may be waiting.

Repeat last minute cancellations or no show to your scheduled appointment may result in the following:

First time Cancellation / No show: Reschedule missed appointment and provide reminder of office cancellation policy.

Second time Cancellation / No show within 12months: Place on wait list to be called for appointment and a letter stating office policy will send to parent/guardian.

Third time Cancellation / No show within 12 months: Dismissal letter along with authorization to release records will be send to parent/guardian.

Appointment for siblings
We understand your time is very valuable; therefore, we can offer appointments for up to 2 siblings from the same family to come in together for their regular check up appointments. However, if you break this type of appointment, any future scheduling will be for only 1 child at a time.

As a courtesy to help remind each parent/guardian of upcoming appointments, we send out several email and text reminders as well as follow-up calls to unconfirmed appointments.

Late Policy
Please understand, for a typical 30 minute appointment, tardiness of even 10 minutes can greatly diminish the time and quality care your child should receive. Please understand that if you are more than 10 minutes late, your child's appointment might be rescheduled to another day, where we can allow enough time for his/her visit.

We strive to offer the very best quality care to your child. We appreciate your cooperation and understanding.

I have read and understood the policies mentioned above.

Print Name: _____ **Date:**_____

Signature: _____