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7001 N. Cherry St.
Gladstone, MO 64118-1898
(816) 548-3400

113 Bluejay Drive, Suite #201
Liberty, MO 64068-1963
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Dear Parents/Guardians:

We appreciate your decision in making Dentistry for Children your oral health care provider, we want to make your child's first visit to us a positive and enjoyable experience. We look forward to working together and providing the best possible oral health for your family.

We are able to better serve you if you bring the following items to the appointment:

- **All necessary paperwork filled out and signed.**
- **A copy of your insurance card or printed information from your insurance company.** *(If you are not able to supply us with this information prior to seeing your child, you will be responsible for paying for that days services before leaving.)*
- **Information regarding your dental benefits as they apply to this pediatric dental practice.**
- **Panorex, X-rays and Records from the patient's previous dental office.**

By arriving 15 minutes prior to the reserved appointment time with all of the above information, it will allow our office time to process your paperwork and have the full reserved time to diagnose and treat the patient completely.

Prior oral health history is essential in a first visit to a new office. Please contact the previous office and have your child's dental x-rays and record of treatment sent to our office before your first visit. These records can be emailed to dfc@kidsdentistkc.com, faxed to 816-548-3401 or hand carried to our office. We appreciate your effort in getting these to us, as it gives your dentist a complete oral health picture and you can avoid additional charges for things you have already had done.

We know parents are very busy and often have a grandparent or close friend bring the children to a dental appointment. To make it easier for you we have enclosed a PERMISSION TO SEEK TREATMENT form. Please fill out the child's name and list whomever you think may bring the child to the dentist at any point. Then sign and have the form notarized, or if you are unable to get it notarized, bring it with you to the first appointment and one of the front desk ladies can witness it instead. This confirms we have your permission to share information with your authorized caregiver, in your absence.

We are looking forward to your first visit in our office and appreciate that you have chosen Dentistry for Children as your complete oral health provider.

Thank You,
Dentistry For Children's Dentists and Staff

Dentistry for Children
Commitment to Patient Care

1. We have created a warm and friendly environment for our patients. In order to help your child better focus on the dental team, create a sense of independence and allow the doctor and staff to develop a personal relationship with your child that makes them feel safe with their oral healthcare providers. We ask that after your initial visit that the child be allowed to go into the treatment area with our dental team by themselves. If there are special circumstances please make the doctor aware of this.

2. Parents/Guardians we recognize you have busy schedules and are trying to accomplish many things while waiting for your child's treatment to be completed. We offer WIFI for your convenience to help with some of these tasks. Your child's dental team asks that you not leave the building during treatment in case the doctor needs to speak to you regarding your child.

3. Our staff is happy to file your insurance for you, please help us by presenting your current Insurance card and photo identification at each visit. Payment of services not covered by your insurance and any co-pays and deductibles are due the day of services. If you are not able to supply us with current insurance information, payment for services is due that day.

4. We have reserved a specified amount of time for you and your child, therefore 24 hours notice of any changes to this reserved time is requested so we may help other patients with urgent dental needs. Please call during normal office hours to make these changes, our normal office hours are Monday- Thursday 8-5 and Friday 8-12.

5. We strive to deliver a high quality of care and work hard to meet our patients scheduling needs, therefore we ask all of our patients to arrive on time for their appointments. This allows the dental team adequate time to complete your child's dental treatment.

Thank you for choosing our office for your dental needs. We understand you have a choice and appreciate your decision to come to Dentistry for Children.

_____ _____

Parent/Guardian Signature Date

PLEASE COMPLETE THE ENTIRE FORM

DATE: _____

PATIENT INFORMATION

Patients Legal Name: _____ Nick Name: _____ Birth Date: _____ Patients Age: _____

Patients Address: _____City: _____State: _____ Zip: _____Male: __ Female: __

Who referred: Dr:_____ Insurance:_____ Friend/Family:_____ Internet/Website:_____

PARENT OR GUARDIAN INFORMATION

Mothers Name: _____ Birth Date: _____ Mothers SSN: _____

Mothers Address: _____City: _____State: _____ Zip: _____

Employer: _____ Home #: _____ Cell #: _____

Work#: _____ Patient resides with mother: yes: ___ no: ___ E-mail Address: _____

Fathers Name: _____ Birth Date: _____ Fathers SSN: _____

Fathers Address: _____City: _____State: _____ Zip: _____

Employer: _____ Home #: _____ Cell #: _____

Work#: _____ Patient resides with Father: yes: ___ no: ___ E-mail Address: _____

EMERGENCY CONTACT NOT IN THE HOME: _____ Cell: _____ Home: _____

If you are Legal Guardian accompanying patient, please give a copy of guardianship papers to the front desk and fill the above section out. Whom may we NOT discuss treatment with regarding this patient: _____

PRIMARY DENTAL INSURANCE OR MEDICAID INFORMATION- PHOTO IDENTIFICATION REQUIRED

Name of Insurance Company: _____ Address: _____ Phone #: _____

Group #: _____ ID #: _____ Insured Name: _____ Birth Date: _____

Insured Address: _____ SSN: _____ Employer: _____ Phone #: _____

SECONDARY INSURANCE OR MEDICAID INFORMATION- PHOTO IDENTIFICATION REQUIRED

Name of Insurance Company: _____ Address: _____ Phone #: _____

Group #: _____ ID #: _____ Insured Name: _____ Birth Date: _____

Insured Address: _____ SSN: _____ Employer: _____ Phone #: _____

I give Dentistry for Children permission to use Nitrous Oxide (laughing gas) and/or local anesthetic as needed to treat this patient. _____ yes _____ no

_____ _____

Signature of Parent or Guardian Date

I give Dentistry for Children permission to take necessary diagnostic films to properly make a complete diagnosis for treatment. _____ yes _____ no

_____ _____

Signature of Parent or Guardian Date

I affirm that the information I have given is correct to the best of my knowledge. I understand it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in the patients' medical status. I authorize the dental staff to perform the necessary dental services for this patient.

_____ _____

Signature of Parent or Guardian Date

PLEASE READ CAREFULLY AND CHECK ALL THAT APPLY, INCLUDE DATES AND SPECIFICS ABOUT A CONDITION. THIS INFORMATION WILL HELP OUR STAFF TREAT THE PATIENT COMPLETELY.

PATIENT NAME_____ DOB_____M/F_____ WEIGHT_____

PROBLEMS AT BIRTH: ___ NONE
___ Complications before or during birth, ___ Premature,___ birth defects, ___inherited conditions,___ growth and development issues
Explain_____

CARDIAC: ____NONE
___ Congenital heart defect, heart murmur ___Irregular heartbeat/palpitations, high blood pressure ___Abnormal ECHO
___ Premedication needed **Explain:** _____
_____

EAR, NOSE, THROAT: _____NONE
__Snoring, sleep apnea, excessive gagging ___Recent strep throat or respiratory infection ___Exposure to tobacco
___Impaired hearing, vision or speech **Explain**: _____
_____

PULMONARY: _____NONE
____ Asthma, reactive airway, breathing problems ___Recent bronchitis/pneumonia, RSV, croup___ Narrow airway
____Cystic fibrosis, tuberculosis **Explain**: _____
_____

GI/GU: ____ NONE
___ Acid reflux, GERD, stomach ulcer, intestinal problems, ___Hiatal hernia ___Hepatitis, jaundice ___Kidney or liver transplant, bladder problems ___Prolonged diarrhea, vomiting ____ Lactose or food intolerance **Explain**:_____
_____

NEUROLOGIC: ____NONE
__Seizures/epilepsy, cerebral palsy, brain injury __ Syncope/dizziness __Muscle paralysis or weakness __Recurrent or frequent headaches, fainting ____ Concussion **Explain**: _____
_____

MUSCULOSKELETAL: ____ NONE
___Arthritis, scoliosis, muscle joint problems ___ Neck movement problems __Muscular dystrophy, __low muscle tone ___ Fractures
Explain_____

PSYCHOSOCIAL: ____NONE
___Development disorders, learning delays ___ADD___ADHD ___Autism
Explain_____

ENDOCRINE/METABOLIC: _____NONE
___Diabetes, hyperglycemia, hypoglycemia ___Thyroid/pituitary ___Adrenal disorder ___Metabolic syndrome ___Precocious puberty or hormonal problems ___Growth Hormones **Explain:** _____
_____

BLOOD DISORDERS: ____ NONE
___Anemia _____ Sickle Cell ___ Bleeding disorder, Easy bleeding or bruising ___Leukemia ____ Transfusion ___Cancer, tumor, chemotherapy, radiation, bone marrow transplant **Explain:** _____
_____

OTHER: ___NONE
___Down syndrome _____ Pierre-Robin syndrome **Explain**: _____
___Hunters syndrome _____ Hurlers syndrome _____

PLEASE FILL OUT THE BACK SIDE ALSO

PLEASE LIST YOUR PRIMARY CARE DOCTOR AND ANY OTHER SPECIALISTS YOUR CHILD SEES:

NAME **PHONE NUMBER** **REASON**

_____

_____

PLEASE LIST ANY MEDICATIONS YOUR CHILD IS CURRENTLY TAKING: Dose and Reason

---

IS YOUR CHILD ALLERGIC TO ANY FOODS, MEDICATIONS, ANESTHESIA, LATEX, and DYES OR METALS: If yes, please list.

_____

THIS CHILD IS CURRENT ON ALL THEIR IMMUNIZATIONS: ___YES ___NO. If no, please explain why.

Has there been any significant changes or disruptions in the patient's family, home or school routine? Yes___ No___ If yes please explain: _____

Is there anything about the patient's family medical or dental history we should be aware of? ___NO ___YES Explain_____

PATIENT ORAL HEALTH:

How would you describe the patient's?

Oral Health: Good:_____Fair:_____Poor:_____ Eating Habits: Good:____Fair:_____Poor:_____

Snacking Habits: Healthy: _____Mostly Sweet:_____ More than 2 times a day_____1 time a day or less____

Breath: Normal:_____Odor:_____ Sucking habits after age 1: thumb:_____Fingers_____Pacifer:_____

How often do you or the patient brush their teeth_____ Floss _____?

Does the patient participate in any sports_____ If so is a mouth guard worn_____

Has your child been treated by another dentist_____ If yes date of last visit_____ Reason for visit_____

X-rays taken _____.

Has your child had any tooth pain or mouth injury since their last visit? Yes____ No_____ If yes please explain_____

Is there anything else we should know or concerns you have, before treating your child? _____ if yes please explain_____

I affirm that the information I have given is correct to the best of my knowledge. I understand it will be held in the strictest confidence and it is my responsibility to inform this office of any changes in the patients' medical status. I authorize the dental staff to perform the necessary dental services for this patient.

_____

Signature of Parent or Guardian Relationship Date

Initial Dr._____ Initial Staff_____

Dentistry for Children

DENTAL DECAY RISK ASSESSMENT AGE 6 & OLDER

Patient Name: _____ Age: _____ Exam date: _____

Risk Indicators- Patient Interview	Yes	No	Notes
A. Child has had recent dental work. (fillings, crowns)			
B. Have you lived in another country in the last 2 years?			
C. Child sleeps w/bottle, sippy cup, or nurses on demand?			
D. Does child have frequent (3 or more times daily) sugary snacks, starches, or sugary beverages between meals?			
E. Saliva reducing factors are present- Medications : asthma or hyperactivity?			
F. Saliva reducing factors are present- Medical: cancer treatments or genetic?			
G. Child has developmental problems?			
H. Caregiver/parents has a history of cavities or periodontal disease?			
I. Does caregiver/parent use tobacco products?			
J. Any saliva transfer (sharing of cups, utensils, or pacifiers)?			
K. Child has a regular dentist?			
L. Child lives in a flouridated community?			
M. Child takes a flouride supplement?			
N. Child brushes with a flouride toothpaste?			

THIS SECTION IS OFFICE USE ONLY

Risk Indicators- Clinical examination of child	Yes	No	Notes
A. Obvious white spots, decalcifications, or obvious decay present on childs teeth?			
B. Any dental work done in the last 2 years?			
C. Plaque is obvious on teeth and/or gums bleed easily?			
D. Gingivitis (gum disease) present, red puffy gums?			
E. Dental or orthodontic appliance present (fixed or removeable)?			
F. Visually inadequate saliva flow (dry mouth)?			
G. Uses flouride mouthwash/rinse/gel daily?			
H. Child has greater then 1 interproximal lesions?			
I. Child has special healthcare needs?			

Child's overall decay risk status: High_____ Moderate _____ Low _____

Recommendations givien: YES NO

Doctor Signature: _____ Date: _____

DENTISTRY FOR CHILDREN
FINANCIAL POLICY

We would like to take this opportunity to welcome you to our office, and to let you know we are committed to providing your family with the best possible care. So there is no misunderstanding as to what our financial policy is, please take time to read and sign this form. We will gladly discuss your proposed treatment and answer any questions relating to your insurance. We reserve the right as the doctor to change treatment as deemed necessary, for the benefit of the patient.

We strive to inform our families of treatment costs prior to services being performed, however should your family require emergency care after hours, weekends or holidays there will be an additional fee that may not be covered by your insurance.

We understand not everyone has access to dental insurance, therefore we offer several ways to take care of your families fees. We offer Care Credit, and accept cash, checks, and most major credit cards. For those families who have dental benefits we will file your claim as a courtesy, provided you supply us with the assignment of benefits and correct insurance information. If this information is not supplied prior to the appointment you will be required to pay for the services that day. In order to continue to deliver a high quality of care to our patients, any patient balance will be due day of service.

Your insurance is a contract between you and the insurance company. Payment to us is your responsibility. Please keep in mind that not all services are covered benefits on all plans and the term **Reasonable and Customary** fee for dental care varies greatly between insurance companies.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise we encourage you to contact us promptly for assistance in the management of your account. From time to time we are faced with families not responding to our help in payment of their bills, for these cases we do use an outside collection agency. After 90 days an 18% finance charge is assessed. If we have to file suit to recover the dental fees, the undersigned shall be responsible for $150 or 20% whichever is greater and any interest charges from the attorney fees incurred to collect the past due amount. We reserve the right to contact the credit bureau if necessary.

If we should receive a returned check from your bank you will be notified and expected to pay your bill with cash or credit card with in two weeks. If you do not respond nor take care of your outstanding balance within one month we will not be able to continue to see the family in our practice. We will make several attempts to reach you regarding the matter but it is your responsibility to take care of the returned check.

So there is no misunderstanding as to what our financial expectations are please read the information carefully and then sign. You may request a copy.

Parent or Guardian Signature

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HIPAA Privacy Authorization Form

*** Authorization for Use or Disclosure of Protected Health Information*

I authorize Dentistry for Children to use and disclose the protected health information for **Patient/Family Name:** _____. This authorization for release of information covers all present and future periods that above named family members are associated with this practice.

I authorize the release of my child(ren) complete health record(s) to be used for medical or dental treatment, consultation, billing or claims payment purposes. I may pay for a service in full and request that Dentistry for Children not submit the protected health information as it pertains to a particular health situation to my dental insurance.

In the event of a breech of the patient's information, Dentistry For Children will make every attempt to notify the legal guardian and explain how it will be corrected.

I give Dentistry for Children permission to E-mail the health information for the patient listed above to the necessary parties as described in this authorization.
I understand that referrals by Dentistry for Children are not based on any special treatment or expectation by the referral source, and that Dentistry for Children refers my child(ren) solely based on need and best professional available for the dental or medical situation.
I understand that my treatment or eligibility for benefits will not be conditional on whether I sign this Authorization. Any information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Printed Name of Parent or Guardian	**Date**
Signature of the Parent or Guardian	**Relationship to Patient**

Privacy Officer for Dentistry For Children
Linda Beaubien
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MAJOR CHANGES CONCERNING YOUR CHILD'S NEXT VISIT EFFECTIVE JANUARY 1st, 2018

Due to the ever changing legal climate regarding all treatment for minor children, **effective January 1st, 2018 we are requiring** all children under 18 years of age, who are not accompanied by a legal parent or guardian to have a **notarized PERMISSION TO AUTHORIZE TREATMENT** form on file. The Permission To Authorized Treatment form does not expire but will need to be updated if there is a change in person(s) you allow to bring your child. If you cannot get it notarized prior to coming please fill out and sign the form in front of our front office staff. You may access the form on our website and it is included in our New Patient paperwork.

The Permission To Authorize Treatment form allows you to choose the person(s) you would allow to bring your child to Operative (dental work) appointments, who is 18 years of age or older. It must be someone the parent/legal guardian feels comfortable with in making any medical decisions about the patient/child we are treating and who we can speak to regarding any treatment. If a Step Parent is bringing the child, they too need to be on the Permission To Authorize Treatment form unless there is legal guardianship/adoption paperwork on file.

We understand that your child is driving and transitioning into adulthood. You may be allowing them to drive themselves and siblings to appointments. We will allow this for **routine cleanings and check –ups** for existing patients. Please understand that a lot of information will be given to the teen at this appointment and we may be discussing treatment needed or referrals. This information will be sent with the teen in written form, but it is your responsibility to decide if the child is able to relay the material to you. Our Pediatric dentists prefer the parent or adult bring the younger children due to the potential amount of material presented and the possible need for scheduling follow up appointments.

Any patient under age 18 having dental operative work must have the parent or predesignated adult accompany and stay at the office during the entire procedure. No exceptions, per doctor. Adverse reactions are always a possibility with any procedure.

If the person bringing the child to the appointment is not on the Permission To Authorize Treatment form, they will be asked for their ID and the legal parent or guardian will be contacted to get verbal permission for that day's visit. We will notate in the chart we have verbal permission and give a Permission To Authorize Treatment form to the person accompanying the child that day. Upon the child's next scheduled appointment, the form will need to be notarized and returned to our office. Only 1 verbal consent will be attempted. Any following appointments where the parent is not present may be rescheduled until consent is received.

If you have questions regarding Dentistry For Children's updated Permission To Authorize Treatment policy. Please contact our Gladstone Pediatric Dental Office at (816) 548-3400

Thank You,
The Dentists and Staff of Dentistry For Children

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PERMISSION TO AUTHORIZE TREATMENT

I/We _____ are unable to bring my child(ren)

_____ to the appointment, I

Give (adults that may bring my child(ren) 1._____

2._____3._____

4._____ permission to seek treatment and have

Details of treatment discussed and can make emergency medical decisions should I be un reachable.

I/We can be reached at one these numbers: 1._____

2._____3._____ if there is an emergency or the Doctor needs to speak to a natural parent or legal guardian.

_____ _____
(Parent's or Legal Guardian's Signature) **(Date)**

_____
(Notary)