Louis Pollina, D.D.S, P.C.
Brandi Roeber, D.D.S.
Aaron Bumann, D.D.S.
Laura Walden, D.D.S. (Teen Dentist)

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

Liberty Office
113 Bluejay Dr. Suite 201
Liberty, MO 64068-1963
(816)-792-1118

Dear

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 best 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 and X-rays and Records from 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 x-rays and dental records sent to our office before this first visit. These records can be emailed to dfc@kidsdentistkc.com, faxed to 816-548-3401 (Gladstone) or 816-792-1120 (Liberty) 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 had done before.

We know parents are very busy and often have a grandparent or close friend bring the children to a dental appointment. To make this easier for you we have enclosed a PERMISSION TO SEEK TREATMENT form. Please fill out the child (rens) name and list whomever you think may bring your 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 sign it in front of one of our front desk ladies who will witness it. This confirms we have your permission to share information with the authorized care giver, in your absence.

If your child is being seen by the Teen dentist Dr. Walden, she has a standard of treatment for her teen patients, a fluoride treatment every 6 months and x-rays at least one time a year. Teens are more cavity prone and need the additional protection of fluoride as well as keeping a close eye on their gum tissue and enamel breakdown that can happen at this age.

If for some reason you are not able to make this scheduled appointment, we must have at least 24 hours' notice or we will not be able to reschedule this appointment.

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 care provider

Thank you, *Dentistry For Children Dentists & 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_____

SUPPLEMENTAL HEALTH HISTORY FOR ADOLESCENTS

Patients Name: ____ Age: ___________

Do you have any concerns about your mouth, teeth or oral health? ____Yes ___No

Describe:____

Have you recently experienced any dental/oral pain? ___Yes ___No

Describe:____

Do you have any concerns with the appearance of your teeth or smile? ____Yes ____No

Describe: ____

Do you bleach your teeth? ___Yes ___No If yes, how often ______________________________

Have you had any recent changes in your diet? ____Yes ____No

Describe:____

Do you participate in contact or high speed sports? ____Yes ___No

We recognize that patients may engage in certain behavior/activities that can have significant consequences on their oral health and /or general health. In addition, medicines that we use to treat oral conditions may interact with drugs (prescriptions, over the counter or recreational) and other substances a patient might be using. Therefore, we encourage our adolescent patients to answer all of the following questions truthfully. If you prefer not to answer an item, we hope you will discuss any concerns confidentially with the dentist.

Do you have any history of the following?

- Oral habits (chewing fingernails, clenching/grinding teeth, ect..) ____Yes ____No
- Tobacco Use ____Yes ____No
- Eating disorders ____Yes ____No
- Oral piercings/jewelry ____Yes ____No
- Alcohol or recreational drug use/prescription abuse ____Yes ____No

Females: Are you pregnant or possibly pregnant? ____Yes ____No

Females: Are you taking oral contraceptives ____Yes ____No

Is there anything you would like to discuss with the dentist confidentially? ____Yes ____No

____

Signature of Patient Date Doctor or Staff signature

I am 18 years of age or older and give my oral health team permission to discuss my dental treatment with my parent or guardian.

____

Patient Name Date Doctor or Staff signature

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

Louis Pollina, DDS, PC
Brandi Roeber, DDS
Aaron Bumann, DDS
Laura Walden-Pollina, DDS
KidsDentistKC.com

7001 N. Cherry St.
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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
7001 N. Cherry Street, Suite 100
Gladstone, MO 64118
(816) 548-3400

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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)