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**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 we have all the following in our office 1 week prior to the appointment. You may email, fax or mail the information:**

- 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.
- Panorax and X-rays and Records from previous dental office.
- Please bring Divorce Decree/Court Order, Guardianship, or Power of Attorney paperwork.

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](mailto: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 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*

# YOUR CHILD'S 1<sup>st</sup> F I R S T DENTAL VISIT

## WHAT SHOULD I DO TO PREPARE MY CHILD FOR THEIR FIRST DENTAL VISIT?

Parents as well as children can be apprehensive about the first dental visit.

**Here are a few suggestions to help make the first visit go smoothly:**

- Read your child a story about going to the dentist.
- Inform our staff about any medical or psychological problems your child may have.
- Make sure your child is well-rested before the dental appointment.
- Play "dentist" with your child at home. Pretend that you are counting teeth then switch roles and let your child be the "dentist."
- If your child is at the right age, openly discuss his or her questions or concerns.
- Do not convey anxiety about the dental visit to your child.
- Do not use negative words like hurt, shot, needle, or drill.
- Do not become upset if your child cries during the first visit. This is normal behavior for young children and infants.
- Discuss your questions and concerns with the doctors.

**First time oral health visits are primarily used to assess your child's risk for dental disease, begin a dental preventive program, and determine the most appropriate dental appointment schedule for your child.**

**During your child's first visit, we will:**

- Inquire about your child's medical history.
- Ask about your child's dietary and feeding habits.
- Evaluate your child's oral hygiene.
- Examine the mouth for dental caries or other problems.
- Assess the need for fluoride supplements.
- Explain age-appropriate oral hygiene techniques.



**KidsDentistKC.com**



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## **Dentistry for Children Commitment to Patient Care**

1. We have created a warm and friendly environment for our patients. We strive to help your child 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 health care provider. When both the dentist and you as a parent feel your child is ready, we would like to start your child coming back to the treatment area by themselves. Our goal is to partner with you, to encourage your child's sense of accomplishment and self-worth in relation to their dental care. Ultimately we want to make you as a parent feel confident in your choice of a dental home for your family.
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 or parking lot 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 home. We understand you have a choice and appreciate your decision to come to Dentistry for Children.**

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Parent/Guardian Signature

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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 you to our office: \_\_\_\_\_

## PARENT OR GUARDIAN INFORMATION

Parent/Guardian: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employer: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Work#: \_\_\_\_\_ Patient lives with: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Birth Date: \_\_\_\_\_ SSN: \_\_\_\_\_ Relationship: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Employer: \_\_\_\_\_ Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_

Work#: \_\_\_\_\_ 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  
\_\_\_\_ Hunters syndrome \_\_\_\_ Hurlers syndrome

**Explain:** \_\_\_\_\_

PLEASE FILL OUT THE BACK SIDE ALSO

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

NAME

PHONE NUMBER

REASON

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

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

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**THIS CHILD IS CURRENT ON ALL THEIR IMMUNIZATIONS: \_\_\_YES \_\_\_NO. If no, please explain why.**

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**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 \_\_\_\_\_

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**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 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 reasonable attorney fees, and 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.

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Parent or Guardian Signature



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Laura Walden-Pollina, DDS  
<https://KidsDentistKC.com>

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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 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 breach 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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## Dear Parent or Guardian,

Due to the ever changing legal climate regarding all treatment for minor children, **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 SEEK TREATMENT

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

\_\_\_\_\_ to the appointment, I

Give (adults 18 years and older 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 or Legal guardian signature)

\_\_\_\_\_  
(Date)

\_\_\_\_\_ Notary