JUST FOR KIDS DENTISTRY / ACQUAINTANCE RECORD

Today's Date: _____

PATIENT NAME: First: _____ Last: _____Nickname/Preferred Name: _____

Date of Birth: _____ Gender: Male/Female Best Contact Number: _____

Patient's Address: _____ City/ST/Zip_____

Patient Primary lives with _____ **FAMILY EMAIL ADDRESS:** _____

How did you hear about our office: _____

PRIMARY Guardian/PARENT : _____ Primary Guardian Date of Birth: _____

Primary Guardian SS#: _____ Primary Guardian DL#: _____

Primary Guardian Relationship to Patient: _____

Primary Guardian Address: _____ City/ST/Zip _____

Primary Guardian Cell #: _____ Work #: _____ Employer: _____

SECONDARY Guardian/PARENT : _____ Secondary Guardian Date of Birth: _____

Secondary Guardian SS#: _____ Secondary Guardian DL#: _____

Secondary Guardian Relationship to Patient: _____

Secondary Guardian Address: _____ City/ST/Zip _____

Secondary Guardian Cell #: _____ Work #: _____ Employer: _____

EMERGENCY CONTACT INFORMATION:(not living with patient) Name: _____

Relationship to child: _____ Cell #: _____ Home #: _____

Address: _____ City/ST/Zip: _____

PATIENT INSURANCE INFOMRATION:

PATIENT PRIMARY INSURANCE: _____ ID#: _____

PATIENT SECONDARY INSURANCE: _____ ID#: _____

TREATMENT CONSENT: I am fully able to answer all questions accurately. The undersigned has the legal authority to obtain dental care for the above named child. Furthermore, I the undersigned hereby authorize Dr. Hoffman and associates to perform the examination and after explanation, the necessary dental services, including radiographs, and those methods deemed appropriate for the care of the above-named child. This consent shall remain in in full force until cancelled by either party.

Parent/Legal Guardian Signature: _____ **Date:** _____

FINANCIAL POLICY: Payment is due at the time services are rendered. Payment may be made by cash, check (under$100), Mastercard, Visa, Discover or Care Credit. Our office is not set up for billing. I understand that if I have to be billed for any reason I have 30 days to make a payment in full or make financial arrangements with the accounts receivable department. Should I have to be billed more than once I understand that there is a $5.00 charge for each statement thereafter. Returned check charge is $30.00 per check. (_____ **initials)**

FOR THOSE PATIENTS WITH INSURANCE: As a courtesy to our patients, we do file your insurance for you. However, it must be stressed that your insurance is a contract between you, your employer and the insurance company. We are not a party to this contract unless you're a member of a PPO group in which the doctor participates. In such cases, we will handle your claims according to our agreement with the insurance company, if one exists. While we do our best to help you receive your maximum benefits, we will not become involved in disputes between you and your insurance company regarding covered charges, secondary insurance, reasonable and customary determinations, etc. Not all services are covered by your plan and every plan is different. If you have any questions about your benefits, please call your insurance company. It would be helpful for you to know your anniversary date, annual deductible and annual maximum. You are expected to pay the estimated portion of your fee at the time services are rendered. However this is just an estimate-if there is a difference after your insurance pays, we will send you a statement. **I realize that I am ultimately responsible for payment.**

I hereby authorize payment of my group insurance benefits, otherwise payable to me, to Dr. Jeffrey A. Hoffman.

Signature: _____

WE ASK THAT YOU STAY WITH YOUR CHILD FOR THE DURATION OF YOUR CHILD' S DENTAL APPOINTMENT. (_____ initials)

NO SHOW POLICY: We have held your appointment time especially for your child. To avoid a **$50 missed appointment /late notice fee**, a 48 hour notice is required. This fee must be paid prior to scheduling any future appointments**. (** _____ **initials)**

LATE ARRIVALS: Late arrival for a scheduled appointment leads to inadequate time to accommodate the remaining patients on the schedule. Late arrivals risk not being seen. If you are over 15 minutes late you may be asked to reschedule. We will try to accommodate you as time permits. However, those patients who are here at their assigned time will be seen first**.** _____**(initials)**

PATIENT NAME: _____ **DATE OF BIRTH :** _____

Is your child currently taking any medications? **Yes / No**
List: _____

Does your child have any allergies (medications or other)? **Yes / nno**
List: _____

Are there any specific questions or concerns that you would like to have addressed today**? Yes / No**

List: _____

Yes	No	Condition
☐	☐	ADD/ADHD
☐	☐	AIDS/HIV+
☐	☐	Anemia
☐	☐	Allergies
☐	☐	Asthma
☐	☐	Autism – Mild/Sever
☐	☐	Behavioral Problems
☐	☐	Birth defects
☐	☐	Blood Transfusions
☐	☐	Bone or Joint Problems
☐	☐	Brain Injury
☐	☐	Cerebral Palsy
☐	☐	Cancer/Tumor
☐	☐	Chemical Dependency
☐	☐	Chemotherapy/ Radiation
☐	☐	Chicken Pox
☐	☐	Child Abuse
☐	☐	Cleft Palate/Lip
☐	☐	Cold Core/Canker Sores
☐	☐	Developmentally Delayed:Age level is
☐	☐	Diabetes
☐	☐	Earaches/Ear Infections
☐	☐	Eye Conditions
☐	☐	Latex Allergy
☐	☐	Seizures - Febrile/ other :

Yes	No	Condition
☐	☐	Hearing Impairment
☐	☐	Heart Disease
☐	☐	Heart Defect
☐	☐	Heart Murmur
☐	☐	Hemophilia
☐	☐	Hepatitis/ Liver Disease
☐	☐	High Blood Pressure
☐	☐	Hospital Stay/ Operation (Please explain)
☐	☐	Injury to Front Teeth
☐	☐	Kidney Disease
☐	☐	Low Blood Pressure
☐	☐	Lupus
☐	☐	Mentally Handicapped
☐	☐	Metallic Implant, Shunts, Pins/Rods
☐	☐	Mononucleosis
☐	☐	Prolong Bleeding When Cut
☐	☐	Psychiatric Care
☐	☐	Rheumatic Fever
☐	☐	Scarlet Fever
☐	☐	Sickle Cell Disease
☐	☐	Sore Throats
☐	☐	Speech Impairment
☐	☐	Thyroid Disease
☐	☐	Tonsillitis
☐	☐	Down Syndrome

If you answered yes to any of the above please explain:

_____

Is there any other health information that we should know? **Yes / No**

Please explain: _____

DENTAL HISTORY:

Is this your child's first dental visit? **Yes / No**

Previous Dentist: _____ Date of Last Visit: _____ Date of Last X-Rays: _____

Has your child experienced any unfavorable reactions from previous dental or medical care? **Yes / No**

Explain: _____

How often does your child brush? _____ Floss? _____ Is tooth brushing being supervised? Yes/no

Does your child receive (circle all that apply) bottled water fluoridated water fluoride (supplement tablets/drops) well water

History of (circle all that apply): Breastfeeding Thumb sucking Bottle habits Sippy cup Teeth grinding/clicking of jaw

Parent/Legal Guardian Signature: _____ **Date:** _____

(only one page is necessary per family)

We understand that at times it is not possible for the parent or legal guardian of a child to bring him/her in for a scheduled appointment or for emergency treatment. You may give permission for others to bring your child by filling out the following. If you leave this section blank only a parent or legal guardian will be allowed to consent to treatment or schedule and appointment. I, as parent or legal guardian of:

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Date of Birth: _____

I give my permission for:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

to obtain dental treatment. Further, I will make sure the above individual(s) are aware of the medical history of my child and can answer all questions required for safe dental treatment. In addition, I understand that treatment plan changes may occur for a variety of reason. I understand and agree that any treatment plan that may have been explained to me is subject to change and in some cases will change the fess quoted to me. Lastly, I will make arrangement for the above individual(s) to bring any necessary insurance forms and/or payment for services rendered at each visit.

Parent/Legal Guardian Signature: _____ **Date:** _____

Just For Kids Dentistry
Jeffrey A. Hoffman, D.D.S.
601 S. Main Street, Suite 220
Keller, TX 76248
817-741-8390

I understand that the staff at Just For Kids Dentistry makes every effort to obtain information as to what my insurance company provides. I understand that they will attempt to calculate my co-payments accurately. I will be responsible for any co-payments, which are due the day treatment is rendered. In addition, Just For Kids staff will go over all treatments that are planned for my child at each visit prior to treatment being rendered.

We are in-network with the following insurance companies, excluding any indemnity plans.

Aetna PPO/Assurant/DHA
Ameritas PPO
Blue Cross Blue Shield of Texas
Cigna PPO
Delta Dental Premier & POS
Dentaquest – Traditional
Guardian PPO
MCNA – Traditional
Principle PPO
Reliance Standard
QCD
UMR plans connected with Guardian

If you do not see your insurance company listed above, we are NOT an in-network provider with your plan. In this case, you may still be seen in our office and we will still file your insurance for you but benefits may be slightly lower. We do NOT accept any HMO insurance.

I understand and agree that I will be responsible for any amounts not paid for by my insurance company, even if the insurance company payment amounts differ from the amounts Just For Kids Dentistry was told either by phone, online or in writing by the insurance company prior to my visit.

_____ _____ _____

Patient Name Parent/ Guardian Signature Date

Facts you should know about your dental insurance:

Dental insurance plays a large and larger role in helping people obtain dental treatment. Since we strongly fee our patients deserve the best possible dental care we can provide, and in effort to maintain the highest quality of care, we would like to share some facts about dental insurance with you.

Although insurance is your responsibility…we can help. Regardless of what we might calculate as your benefit in dollars, we must stress the fact that you are responsible for the total cost of you dental care. As a courtesy to you, we will file your insurance to get the maximum amount due you under your plan's provision. You should contact your employer or union to obtain precise information regarding your benefits.

You may receive a letter from your insurance company stating that dental fees are higher than usual and customary, rather than saying their benefits are low. An insurance company surveys a geographic area, finds the average fee and then takes 90% of that fee and considers it customary.

Many plans tell their insured that they will be covered "up to 80% or up to "100", but do not clearly specify limitations. We have found that most plans cover about 35% of 65% of major services based on the plan's pre-established maximum fee allowances and vary from carrier to carrier.

And many routine dental services are not covered by insurance carriers.

In the event you do not receive the benefits that you believe you have purchased from your insurance carrier, contact your employer's benefits department., your insurance company representative, your union agent, the State Department or the Attorney General's office. Since the dentist is not the owner of the policy, these agencies refuse to solve problems when petitioned by the doctor. However, as always, we will be glad to assist you in any way we can to assure you get your maximum benefits.

Ke: HH 1-3