Southfield
Kids Dentist

18900 W. 10 Mile Road • Southfield, MI 48075
O: 248.565.3332 • F: 248.483.0800
www.southfieldkidsdentist.com • southfieldkidsdentist@gmail.com

PATIENT INFORMATION

Child's Last Name: _____ First: _____ Middle: _____

Is this your legal name? ❑ Yes ❑ No If not, what is your legal name?: _____

Nick Name: _____ Birth Date: _____ Age: Sex:

Street Address: _____ Social Security #: _____

Home Phone #: _____ P.O. Box: _____

City: _____ State: _____ Zip: _____

Mother's Last Name / First Name / Initial: _____

Marital Status: _____ Email: _____ Mother's Phone #: _____

Father's Last Name / First Name / Initial: _____

Marital Status: _____ Email: _____ Father's Phone #: _____

Who may we thank for referring you? We would like to thank them: Dr. _____ ❑ Insurance Plan ❑ Hospital

INSURANCE INFORMATION

Please give your insurance card or insurance information to the receptionist

Person responsible for the bill: _____ Birth Date: _____

Address (if different): _____ Home Phone: _____

Is this person present today: ❑ Yes ❑ No

Occupation: _____ Employer: _____

Employer Address: _____ Employer Phone: _____

Please indicate primary insurance: ❑ PPO ❑ HMO ❑ EPO ❑ State Medicaid

Subscriber's Name: _____ Subscriber's S.S.#: _____

Birth Date: _____ Group #: _____ Policy #: _____

Patient's relationship to the subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other _____

LANGUAGE

Languages spoken by Patient / Family: ❑ English ❑ Spanish ❑ Arabic ❑ Other: _____

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the dental practice. I understand that I am financially responsible for any balance. I also authorize Southfield Kids Dentist, PLLC or inisurance company to release any information required to process my claims.

Patient / Guardian Signature: _____ Date: _____

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PATIENT MEDICAL & DENTAL HISTORY

Name: _____ DOB: _____ Age: _____

Pediatrician / Family Physician: _____ Phone #: _____

Please mark/circle the appropriate response. If your answer is YES, please provide a brief explanation.

Medical Condition	Yes	No	Medical Condition	Yes	No
Acid Reflex / GERD?			Immunizations up to date?		
ADHD / ADD?			Learning disability or developmental delay?		
Autism?			Kidney or bladder problem?		
Asthma?			Nervous system problem?		
Blood disease or bleeding disorder?			Pregnant?		
Blood Transfusion?			Psychiatric/psychological counseling?		
Cerebral Palsy?			Radiation therapy / Chemotherapy?		
Endocrine Disease (i.e. thyroid, diabetes)?			Respiratory and/or breathing problems?		
Has your child ever had surgery?			Seizure disorder?		
Has your child ever been hospitalized?			Shunt?		
Hepatitis or Jaundice?			Skin, bone or hair problem?		
Heart disease or Murmur?			Stomach or intestine problem?		
History of reaction to anesthesia or sedation?			Tuberculosis?		
History of rheumatic fever?			Vision impaired?		
Is your child allergic to?			Penicillin Erthromycin Sulfa Food Other		
Please explain further if you answered YES:					
Is your child currently under the care of a physician?					

Dental History	Yes	No
Is this your child's first dental visit?		
Any unhappy dental experienced?		
Why did you bring your child to our office today?		
Any previous injuries to mouth, teeth or head?		
Who brushes your child's teeth? Times per day?		
How do you expect your child to react to treatment?		

I certify to the accuracy of the above patient history.

Signature of Parent / Guardian: _____ Date: _____

Reviewed By: _____ Date: _____

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AUTHORIZATION FOR OTHERS TO CONSENT TO DENTAL CARE

I hereby give permission for the following person:

First and Last Name: _____

Relationship to Child: _____

To bring my child into Southfield Kids Dentist for dental care. This includes, but is not limited to: dental cleaning's, fluoride treatment, x-rays and restorative care. He or she also has my authorization to make any decision based on the Doctor's and their Associate's recommendation(s) regarding treatment in my absence. I agree to assume financial responsibility for his and/or her decisions at that time.

This consent is valid from date signed until revoked by parent or legal guardian.

This consent is valid for the children listed below:

Child's First & Last Name	Child's Date of Birth

Signature of Parent / Guardian: _____ Date: _____

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CONSENT FOR TREATMENT

Because your child is a minor, signed permission is required from a parent, or legal guardian before any dental treatment can be rendered. I authorize Doctors at Southfield Kids Dentist to perform a dental exam, including x-rays such as bitewings/partopical/panoramic/caphalometric/creats models for teeth and photographs of my child. The Doctors are given permission to use local anesthetic and nitrous oxide as indicated by them. I understand that Doctors and the staff use behavior guidance techniques such as praise, voice control with verbal voice tones and to aid in cooperation of my child during treatment. I understand that, at any time, I have questions I may speak to the doctor treating my child. I can ask questions until I have received satisfactory answers to my questions.

I have read and agreed to the Consent for Treatment.

Signature: _____ Date: _____

PRIVACY PRACTICES

Federal and State law requires the privacy of all health information. I acknowledge that I have received this Notice of Privacy Practices for my child.

Signature of Parent / Guardian: _____ Date: _____

Witness: _____ Date: _____

OFFICE POLICY / PAYMENT INFORMATION

The adult who brings the child to the office is financially responsible. Your appointment time will be reserved especially for your child. If you are unable to keep your appoitnemnt, we require 24 hours notice; otherwise, it may be necessary to charge you at least twenty five dollars per veery thirty minutes for lost time.

Co-payments and behavior management fees must be paid in full before any treatment is provided. Payment is due at the time of service; we accept cash/debit and credit cards including Visa, Mastercard, Discover and American Express. Balances over 90 days past due will be turned over to a collection agency. In this event, you will be responsible for all collection and legal fees.

I have read all of the information and completed this form. I certify that by signing this I am the minor's legal parent/guardian.

Signature: _____ Date: _____

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THIRD PARTY FINANCIAL AGREEMENT

The charges for all dental treatment rendered by Doctors and/or Staff at Southfield Kids Dentist, PLLC are the responsibility of the parent/legal guardian of the patient.

As a courtesy to our parents, we will complete and file insurance forms relative to services rendered. We are obliging the parents of our patients by agreeing to wait up to ninety (90) days to receive payment from the insurance companies involved.

When determining your co-payments, we can only ESTIMATE the amount your insurance company will pay. If there is any balance remaining upon receipt of payment from the perspective insurance, it will become the responsibility of the parent/legal guardian.

I understand the above stated policy and agree to pay for any services provided to my child that are not covered by the insurance company(ies) involved.

Signature of Parent / Guardian: _____ Date: _____

Witness: _____ Date: _____

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OFFICE POLICY

Dear Parents,

I would like to welcome you to my pediatric practice. We will strive to give you the best care possible. To do this, we will need you to be aware of the following:

- The practice is limited to the speciality of Pediatric Dentistry. We generally limit a child's first dental visit with us to: exam/prophyaxis (cleaning) / fluoride / x-rays (if necessary). Exams performed and x-rays taken are based on need and visual findings. School-time appointments are sometimes necessary, and we provide the appropriate documentation for excused absences.

- We have come to realize through years of experience that when dealing with children, they behave more independently when parents are not with them in the operatory while restorative work is being performed.

- PLEASE remember that your dental insurance policy is between you and your insurance company and not with the doctor and your insurance company.

- Behavior management fees are charged by all pediatric dental specialists, and may range from $50.00 to $200.00. Should your child need to be sedated, you will be assessed a fee, which may not always be covered by your dental insurance policy.

- We will strive to value your time and will be as punctual as possible. To evaluate and treat your child properly, we do not schedule anyone else in your child's time slot. If you are more than 15 minutes late, we will unfortunately need to reschedule. We try to remind parents by phone of appointments scheduled, however PLEASE DO NOT DEPEND ON THIS COURTESY. We require at least 24 hour cancellation notice or any time before the day of the appointment to avoid a $25.00 fee due before you can make another appointment.

- The more informed you are about your child's treatment, the more effective we can be.

We are honored that you have placed your trust in us to preserve your child's dental health. It is a pleasure to be of service to you and your child.

~Dr. Ife

Signature of Parent / Guardian: _____ Date: _____