Just Kids, Inc.

New Patient Questionnaire

Child's Name_____ **Nickname**_____
Birth Date_____/_____/_____ **Age**_____ **Sex**_____ **Weight**_____
Child's Physician _____**Physician's Ph #**_____
Preferred Language_____ **Would you like us to provide translation?** _____

Have any of your other children been to Just Kids Dental Office before? Yes No
If so, what are their names? _____
Has your child been to the dentist before? Yes No Last visit _____
Were x-rays taken? Yes No Date_____
Has your child ever injured their teeth? Yes No
If yes, explain: _____
Does (or did) your child have any of the following habits?
___Clenching or grinding teeth ___Finger or thumb habit
___Mouth breathing ___Pacifier

Medical History

Is your child in good health? Yes No
If no, please explain: _____
Is your child taking any medication? Yes No
If yes, please list: _____
Is your child sensitive/allergic to any medication? Yes No
If yes, please list: _____
Is your child sensitive/allergic to any foods? Yes No
If yes, please list _____
Is your child sensitive/allergic to **Latex?** Yes No
Does your child bruise easily? Yes No
Does your child bleed excessively when cut? Yes No
Was your child ever hospitalized or had surgery? Yes No
If yes, when: _____ Why: _____
Does your child have (or had) any of the following conditions?
If yes, state when diagnosed. _____

Any behavioral/neurological disorders (Autism, ADHD, Developmental Delay): _____

Asthma (or Reactive Airway Disease)	Yes No	Diabetes	Yes No
Digestive disorders	Yes No	Rheumatic fever	Yes No
Cancer	Yes No	Allergies	Yes No
Cerebral Palsy	Yes No	Liver disease	Yes No
ADD/ADHD	Yes No	Kidney disease	Yes No
Seizures	Yes No	AIDS/HIV positive	Yes No
Anemia	Yes No	Auto Immune Disorder	Yes No
Tuberculosis (or exposure)	Yes No	Blood disorder	Yes No
Hepatitis A, B or C	Yes No	Frequent ear infections	Yes No
Heart Murmur/Disease/defect?	Yes No		
If Yes is Pre-Med Required?	Yes No	Name of Cardiologist: _____	

Any other condition not listed above: _____

The signature of the parent/guardian below authorizes dental providers at Just Kids Inc. to perform routine dental exams, x-rays, cleanings and required dental treatment. I am aware of the minimum 24 hour cancelation policy of Just Kids and am aware if I do not give 24 hours' notice prior to cancelation I could be charged a deposit of $25 per child to reschedule. I am also aware that if I do not call in advance to cancel, my family could be dismissed from the Just Kids practice.

_____ _____ _____
Signature Relationship to patient Date

I hereby authorize my insurance company to make payment directly to Just Kids, Inc., and authorize release of any necessary and pertinent documents. As the parent/legal guardian of a minor patient, I hereby agree to accept financial responsibility for dental treatment provided by Just Kids, Inc. I acknowledge that I am financially responsible for all charges whether or not paid by insurance.

_____ _____ _____
Signature Printed Name Date

CONSENT TO RECEIVE PHONE CALLS AND FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PARENT/GUARDIAN GIVING CONSENT

Name: _____

Address: _____

Telephone: _____

Patient name(s): _____ Social Security # _____

SECTION B: TO THE PARENT/GUARDIAN----PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your child's protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this Consent. Our Notice provides a description of our treatment, payment activities, and healthcare operations, of the uses and disclosures we may make of your child's protected health information, and of other important matters about your child's protected health information. A copy of our Notice accompanies this Consent. We encourage you to read it carefully and completely before signing this Consent.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your child's protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our Notice, at any time by contacting:

Sam: 907-333-5437

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat your child or to continue treating your child if you revoke this Consent.

In accordance with The Telephone Consumer Protection Act of 1991 (TCPA) and Health Insurance Portability and Accountability Act (HIPPA), we may send information including protected health care information, demographic, or billing information that may individually identify you or the patient and that relates to past, present, or future health conditions and related health care services and payment for the purpose of treatment and billing. Our complete privacy practice policy is available upon request.

SIGNATURE

I, _____, have had full opportunity to read and consider the contents of this Consent form **and** your Notice of Privacy Practice. I understand that, by signing this Consent form, I am giving my consent to your use and disclosure of my child's protected health information to carry out treatment, payment activities, and health care operations. As well as receiving calls and texts from Just Kids Inc. and its associates for the protected healthcare information, accounting and other services of mine and the above listed patient(s) at the phone number listed above. I understand that I may be charged for such calls and texts by my wireless carrier.

Signature: _____ Date: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT FORM AFTER YOU SIGN IT.

Just Kids, Inc.

Family Information

Patient's Name_____

Address_____City_____Zip_____

Phone Number_____ Email:_____

Parent/Guardian 1 Name _____ Home phone _____Work phone_____

Address (if different) _____ City _____ Zip _____

Employer _____ Birth Date _____/_____/_____

Social Security # _____-_____-_____

Parent/Guardian 2 Name _____ Home phone_____ Work phone _____

Address (if different) _____ City _____ Zip _____

Employer _____ Birth Date _____/_____/_____

Social Security # _____-_____-_____

Primary Insurance: _____

Group#_____ ID Number: _____

Name of Insured / Employee: _____

Secondary Insurance: _____

Group#_____ ID Number: _____

Name of Insured / Employee: _____

Emergency contact: _____ Phone: _____

Whom may we thank for recommending Just Kids, Inc.? _____

I hereby authorize my insurance company to make payment directly to Just Kids, Inc., and authorize release of any necessary and pertinent documents. As the parent/legal guardian of a minor patient, I hereby agree to accept financial responsibility for dental treatment provided by Just Kids, Inc. I acknowledge that I am financially responsible for all charges not paid by the insurance company. I am also aware that an estimated portion of treatment cost will be collected the day of treatment for all patients with insurance, apart from DKC policy holders. There is no interest or finance charge on current accounts. After 60 days, all accounts are subject to a Finance Charge of .87% monthly (10.5% annually) of the unpaid balance (or a minimum charge of 50 cents).

_____ _____

Signature Printed Name Date