KIDS FIRST PEDIATRIC DENTISTRY

Matt Karsten, D.M.D. & Associates

Welcome!

It is with great pleasure that we welcome you to our office. We would like to thank you for selecting Kids First Pediatric Dentistry for your child(ren)'s oral health needs. Be assured that this visit will be unique; we will exceed all of your expectations!

Today on your first visit your child(ren) will have a complete, thorough examination of his/her mouth and surrounding tissue and we will update any necessary radiographs. Upon completion of your examination the Doctor will discuss the dental treatment plan required to achieve "optimum dental health". Any questions you may have pertaining to your oral health will be completely covered to your satisfaction.

We want you to know that we are very interested in you and your needs. We have the desire to listen, really listen to what you have to say. Please don't hesitate to ask us about anything. Your child(ren) will be cared for by members of a dental team whose primary purpose is to serve them. A meaningful result comes from a close relationship between Doctor, team and our patient's. Our goal is that you always complete your visit feeling well cared for.

Healthy wishes,

Dr. Matt Karsten and Team

Specializing in dentistry for all children

1640 Capital Street, Suite 500 • Elgin, IL 60124
75 W. Schaumburg Road • Schaumburg, IL 60194
info@kidsfirstpd.com • website www.kidsfirstpd.com

KIDS FIRST
PEDIATRIC DENTISTRY

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Health History Form

Today's Date: ______________________

NOTE: The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name ______________________
Last First M

Goes by: ______________ ☐ Male ☐ Female

Siblings that we treat ______________________

Child's Birthdate ___/___/___ Child's Age ________

School ______________ Grade ________

Child's Home # (____) ______________________

Child's Home Address: ______________________

City State County Zip

2. Mother's Information

Name ______________________

Mother Stepmother Guardian Birthdate ___/___/___

Employer ______________________

Home Address (if different from child) ______________________

City State County Zip

Work # (____) ______________ Ext. ________

Home # (____) ______________________

Cellular Phone # (____) ______________________

SS # ______________ DL# ______________

Email address: ______________________

3. Father's Information

Name ______________________

Father Stepfather Guardian Birthdate ___/___/___

Employer ______________________

Home Address (if different from child) ______________________

City State County Zip

Work # (____) ______________ Ext. ________

Home # (____) ______________________

Cellular Phone # (____) ______________________

SS # ______________ DL# ______________

Email address: ______________________

4. Who is Accompanying the Child Today?

Name ______________________

Relationship ______________________

Do you have legal custody of this child? ☐ Yes ☐ No

5. Person Responsible for Account

Name ______________________

Relationship ______________________

Billing Address ______________________

City State Zip

Home # (____) ______________________

Work # (____) ______________________

Cellular# (____) ______________________

E-Mail ______________________

6. Primary Dental Insurance

Insurance Co. Name ______________________

Insurance Co. Address ______________________

Insurance Co. Phone # (____) ______________________

Group # (Plan, Local, or Policy #) ______________________

Policy Owner's Name ______________________

Relationship to Patient ______________________

Policy Owner's Birthdate ___/___/___

Social Security # ______________________

Policy Owner's Employer ______________________

7. Secondary Dental Insurance

Insurance Co. Name ______________________

Insurance Co. Address ______________________

Insurance Co. Phone # (____) ______________________

Group # (Plan, Local, or Policy #) ______________________

Policy Owner's Name ______________________

Relationship to Patient ______________________

Policy Owner's Birthdate ___/___/___

Social Security # ______________________

Policy Owner's Employer ______________________

8. Who may we thank for referring you to our office?

____

9. Dental History

Is this your child's first visit to the dentist? ______

If not, how long since the last visit to the dentist? ______

Previous Dentist's Name______

Were any x-rays taken at previous dental visits? ______

Have there been any injuries to the teeth, face or mouth? ______

If yes, please explain: ______

______

______

Why did you bring the child to the dentist today? ______

______

______

______

Does the child have any of the following habits?

Y N	Lip Sucking/Biting	Y N	Nail Biting
Y N	Nursing/Bottle Habits	Y N	Thumb/Finger Sucking

Has the child ever had a serious or difficult problem associated with previous dental work? Yes No

If yes, please explain ______

______

Is the child's water fluoridated? Yes No

Is the child taking fluoride supplements? Yes No

Has the child ever had any pain or tenderness in his/her Jaw/ joint? (TMJ/TMD)? Yes No

Does the child brush his/her teeth daily? Yes No

Floss his / her teeth daily? Yes No

10. Health History

Has the child ever had any of the following conditions?

Y N	Abnormal Bleeding	Y N	Disabilities/Special Needs
Y N	Allergies to any Drugs	Y N	Hearing Impairment
Y N	Any Hospital Stays	Y N	Heart Disease/Murmur
Y N	Any Operations	Y N	Hemophilia/Blood Disorder
Y N	Asthma	Y N	Hepatitis
Y N	Cancer	Y N	HIV +/ AIDS
Y N	Congenital Birth Defects	Y N	Kidney/Liver Conditions
Y N	Convulsions/Epilepsy	Y N	Rheumatic/Scarlet Fever
Y N	Pregnancy	Y N	Allergies to Latex Products
Y N	Tuberculosis	Y N	Diabetes
Y N	ADD/ADHD	Y N	Autism

Please discuss any serious medical conditions the child has had

______

______

Please list all drugs the child is currently taking ______

______

Please list all drugs the child is allergic to ______

______

Child's Physician ______

Phone (______) ______

Is the child currently under the care of a physician? Yes No

Please describe the child's physical health...

Good Fair Poor

Our office is committed to meeting or exceeding the standards of Infection control mandated by OSHA the CDC, and the ADA.

11.

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

______ Signature of Parent or Guardian ______ Date ______ Relationship to Patient

For Office Use Only

I verbally reviewed the medical / dental information above with the parent/ guardian and patient named herein.

Initials ______ Date ______

If yes, please explain: ______

______

______

______

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Account Payment and Insurance Processing

We **ESTIMATE** your insurance benefits based on the information we attain from your insurance company as accurately as possible. Changes in benefits and exclusions, may be unique to your policy, and result in a refund or additional balance due after your insurance has paid.

Insurance is a benefit provided by your employer and it is ultimately your responsibility to understand how it pays for services. We are delighted to help you ***but please understand that we base your estimate based on the information provided to us about your coverage.*** For your convenience we provide two options to process your insurance:

☐ I have provided current insurance information 48 hours prior to my child's visit. As a courtesy the insurance coordinator will file primary & secondary insurance on my behalf.

☐ I have **not** provided current insurance information within 48 hours prior to my child's visit and **will pay** for services rendered. The insurance coordinator will provide me with a list of transactions for me to submit to my insurance company for reimbursement.

In the event the balance for services are not paid in a timely matter, it is understood and agreed that the outstanding balance will accrue interest at a rate of 1 ½ % per month, 18% per annum. In the event that the balance is not paid and our office is forced to use an outside collection agency and/or law firm, it is understood and agreed to that a collection fee of up to 30% of the balance due will be added as collection fees.

Please sign and date at the bottom portion of this form that you understand your insurance benefits, filing and billing. If someone other than yourself is responsible please have them review and sign. This will ensure that the account holder is accepting responsibility for any out-of-pocket charges.

*In case of divorce, regardless of any divorce decree, the responsible party is the person who brought the child to the appointment. Our office will not intervene should payment issue arise. In the event someone other than the responsible party accompanies the child please discuss this with a team member.

Signature: ______________________________ Date: ____________

Print your name ____________________________

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Permission for Dental Treatment

I, being the parent or guardian of the child(ren) listed below, do hereby request and authorize the dental staff to perform necessary dental services for my child, including x-rays, nitrous oxide (laughing gas), and any services deemed advisable by the doctor, even ifI am not present in the room during the dental treatment. I understand procedures will be explained to me prior to them being administered to my child.

I give my permission for Dr. Karsten and Associates to perform necessary behavior modifications, to help render safe treatment for my child(ren), such as, giving positive reinforcement, providing compliments, approval, encouragement, and affirmation. Other accepted behavior management techniques used to control behavior during dental treatment include, but are not limited to, "tell,show,do, and "voice control".

My questions and concerns regarding this permission statement have been explained to my satisfaction by Dr. Karsten or his staff. I therefore understand the above statement and consent to the use of the above procedures if deemed necessary by Dr. Karsten and Associates.

Date ______________________

Child(ren)'s Name(s) ______________________________________

____

____

____

Parent/Guardian Signature ____

Cancellation/Late Policy

Please be courteous to other patients who are on a wait list and allow 48 hours for any cancellation of scheduled appointments. If you have to cancel a scheduled appointment without proper notification please note that you will be charged a $65.00 missed appointment fee and that it may be a few weeks to get your child rescheduled for their visit. *We DO understand children get sick and there are emergencies. In that case please just call us ASAP.

Please be understanding of the time we set for your child's care. **If you are <u>15 minutes or more late</u> for your given appointment we will have to reschedule for another day when we will have adequate time to give your child the proper care he/she deserves!** Thank you for understanding!

Signature ________________________________ Date ____________________

Any returned checks will be charged any and all bank fees plus a $25.00 Service Fee.

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PATIENT'S ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY RULES

I, ____________________ have received a copy of the Notice of Privacy Practices of the office of Dr. Matt Karsten and Associates.

Please sign and Date: ____________________

OR **<u>I decline</u> to sign the Acknowledgement.** (circle if you decline)

Please circle **I do** or **I do not** to each of the following:

I do OR **I do not** want appointment reminder messages left on my home answering system. I understand that the office may charge me should I fail to keep my appointment.

I do OR **I do not** want appointment reminders left on my business answering system. I understand that the office may charge me should I fail to keep my appointment.

I do OR **I do not** wish my protected health care information to be released. If you do then only to the following persons: ____

Please print your name : ____

Office use:
The office was unable to obtain a signed Acknowledgement form from the above patient for the following reasons :

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Can we have your email address?

____

We use this to CONFIRM APPOINTMENTS!

It's easier for you to communicate with us, and avoid missing calls. Now you can confirm, change, and request appointments when it is most convenient for you, even in the middle of the night when the kids are finally asleep!

We use this to SEND YOU A SURVEY!

We will send you a quick 5 question survey after your visit with us! If you fill it out you will be helping us stay on top of our patient care.

Thank You!!!

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