KIDS' DENTIST™ ONLINE FORM

3201 East Olive Road, Suite B
Pensacola, FL 32514
850.477.1722
DATE:_____/_____/_____

PATIENT INFORMATION

Child's Name: _____ Goes by: _____

Child's Date of Birth: _____/_____/_____ Age _____ Sex: M or F SS#: _____-_____-_____

Child's Home Address: _____

City, State, Zip: _____

Primary Contact Phone Number: (_____)-_____-_____ School This Child Attends: _____ Grade: _____

Please tell us about the patient's interests and hobbies:

_____

Child Lives With: ( ) Both Parents ( ) Mother ( ) Father ( ) Splits time with _____ ( ) Grandparent _____
( ) Step-parent _____ ( ) Foster Care ( ) Other_____

PERSON FILLING OUT PAPERWORK

Name: _____ Relationship to patient: _____

If other than parent, Legal Guardianship paperwork is required before any treatment can be rendered Are you permitted by law (by right as a natural parent, legal guardian, legal adoption, or court order) to provide consent for the dental treatment of this child? ( ) Yes ( ) No

_____
Signature

PARENT'S/GUARDIAN'S INFORMATION

Mother Step Mother Guardian

Name: _____ DOB: ___/___/____

SSN: _____/_____/_____

Address: _____

City, State, & Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer Name: _____

Occupation: _____

Job Title: _____

Email: _____

___Father ___Step Father ___Guardian

Name: _____ DOB: ___/___/____

SSN: _____/_____/_____

Parents live at same address

Address: _____

City, State, & Zip: _____

Home Phone: _____

Cell Phone: _____

Work Phone: _____

Employer Name:_____

Occupation: _____

Job Title: _____

Email: _____

Do you have other children who are already established patients with our practice?

If yes, name of patient(s): _____

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PATIENT MEDICAL/DENTAL HISTORY

Primary Care Physician_____ Phone #_____ Date of last exam _____

Is this child taking Medicine now? No ( ) Yes ( )

List any Medications: Treatment for: Notes:

_____ _____
_____ _____
_____ _____
_____ _____

Has this child ever been hospitalized? No ( ) Yes ( ) WHY?_____
Has this child ever been treated in the emergency room? No ( ) Yes ( ) WHY? _____
Does this child have or has this child ever had any of the following conditions?

Yes ( ) No( ) Allergies
Yes ( ) No( ) Drug Reactions
Yes ( ) No( ) Latex Sensitivity
Yes ( ) No( ) Asthma
Yes ( ) No( ) Breathing Problems
Yes ( ) No( ) Premature/Low Birth Weight
Yes ( ) No ( ) Anemia
Yes ( ) No ( ) Bleeding Problem/Transfusion
Yes ( ) No ( ) Sickle Cell Anemia
Yes ( ) No ( ) Heart condition/Murmur
Yes ( ) No ( ) Rheumatic Fever
Yes ( ) No ( ) TB, HIV, Hepatitis Type-_____
Yes ( ) No ( ) Kidney Disease
Yes ( ) No ( ) Liver Disease
Yes ( ) No ( ) Jaundice
Yes ( ) No ( ) Frequent Headache

Yes ( ) No( ) Hypertension
Yes ( ) No( ) Diabetes/Endocrine System
Yes ( ) No( ) Cancer type: _____
Yes ( ) No( ) Birth defects _____
Yes ( ) No( ) Cleft lip and/or palate
Yes ( ) No( ) Cerebral Palsy
Yes ( ) No ( ) Delayed speech development
Yes ( ) No ( ) Developmentally Delayed
Yes ( ) No ( ) Seizures type _____
Yes ( ) No ( ) Fainting spells
Yes ( ) No ( ) Hyperactivity/ADD/ADHD
Yes ( ) No ( ) Psychiatric/Emotional problems
Yes ( ) No ( ) Vision problems
Yes ( ) No ( ) Hearing loss/impairment
Yes ( ) No ( ) Pregnancy
Yes ( ) No ( ) Frequent infections

Other medical concerns: _____
What brings you in today? (What is your main dental concern?)_____
Has your child previously seen a dentist? ( ) No ( ) Yes: what dental practice, name of dentist? _____
How often does the patient brush? _____ Floss? _____ By Whom? _____
Does this patient have a special diet? ( ) No ( ) Yes _____
What does child drink on an average day? ( ) Cows milk ( ) Juice ( ) Breastmilk ( ) Water ( ) Gatorade ( ) Soda ( ) Energy drinks ( ) Coffee ( ) Favorite drink _____

I certify that I have read and understand the above information is to the best of my knowledge. the above questions have been accurately answered. I understand that providing incorrect or incomplete information can be dangerous to the health of this patient. I will not hold Dr. Rachel Witcher or any staff responsible for any errors in omissions that I may have made during the completion of this form.

Signature x_____ Date: _____

REFERRAL INFORMATION

How did you hear about our office? (Check all that apply.)

( ) Family/Friend: _____
( ) Dr's Office: _____
( ) Magazine
( ) First pediatric dentist that popped up on Google
( ) Most established office that popped up on Google
( ) Facebook
( ) Google
( ) Insurance company
( ) Promotional offer _____
( ) Other _____

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DENTAL INSURANCE INFORMATION

( ) No, I don't have dental insurance
( ) Yes, I have dental insurance (please give card to front desk to scan or email electronic copy to info@thekidsdentalplace.com

Insurance Company: _____

Policy Number: _____

Name of Policy Holder: _____

Group number: _____

Date of Birth: ____/____/___ SS# _____/___/_____

Insurance Phone Number:_____

( ) I have provided my insurance card to front desk to be scanned
( ) I do not have my card with me to provide to front desk but will email to info@thekidsdentalplace.com when I get home

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I, _____ acknowledges receipt of a copy of the current effective Notice of Privacy Practices policy. A copy of this signed, dated acknowledgment shall be effective as the original.

_____

Signature

OFFICE POLICY FORM/CONSENT PRACTICES

Please read and initial next to each paragraph.

____ I understand that an initial and recall dental appointment can include a visual exam of the oral area, a radiographic (x-ray) exam, prophylaxis (cleaning), Fluoride treatment, and Oral Hygiene Instruction (OHI) when necessary. I understand that digital photographs will be taken as part of my child's clinical record. I give permission to Dr. Rachel Witcher and her team to perform these examinations and procedures on my child at the initial and each subsequent recall appointment. I understand that these services are Dr. Rachel Witcher's standard of care based on the American Academy of Pediatric Dentistry guidelines, and are not based on insurance benefits or coverage frequency.

____ Please be advised that scheduling an appointment is your confirmation of the appointment. Not being contacted by the office is not an excusable reason for any missed appointments. As a courtesy to others who would like to be scheduled, there is $25.00 no show/cancellation fee for missed or cancelled appointment without 24 hours notice.

____ We are a specialty clinic and all fees are due at the time of service. Some services require to be prepaid in order to reserve an appointment time. As a courtesy, we will provide an insurance claim form to be mailed by the patient/guarantor.

____ Be sure to arrive at your appointment on time. We respect our patients' time and make every effort to remain on schedule. If more than 10 minutes late to scheduled appointment, visit may need to be rescheduled. Dr. Rachel Witcher will not "rush" to "make up" the time lost.

____ Electronic Communication Consent: I agree that this practice may electronically communicate with me through the email address and phone numbers I have provided.

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PATIENT AUTHORIZATION FORM

I consent to the following people, whether legal guardian or not, to bring my child in for their dental appointment and give these people the ability to make dental/medical treatment decisions for my child:

1. I give authorization to release medical Information to Family Member(s), Guardian, and others.
2. I give authorization for consent for Family Member(s), Guardian, and others to accompany patients to dental/medical appointments.
3. I give authorization for Family Member(s), Guardian, and others to consent to dental/medical treatment.

Name: _____ Relation to Patient: _____
Name: _____ Relation to Patient: _____
Name: _____ Relation to Patient: _____
Name: _____ Relation to Patient: _____

When will caregiver's authorization begin? Date: _____

Do you want to set an end date? Yes or No (please circle one)
If yes, Date: _____

_____
Patient Name (Please Print)

_____
Legal Guardian name (Print)

_____ _____
Legal Guardian Signature Date

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CONSENT FOR TREATMENT

(Please include all patient names' below, including siblings to consent for treatment at our practice.)

Patient Name(s): _____

I, being the parent or guardian of the above minor patient(s), hereby do authorize and request the performance of dental services for the patient(s) and the use of whatever procedures the doctor may deem necessary during treatment.
I understand that Dr. Bonnin, Dr. Rachel, and Dr. Witcher, as well as, assistants as he may designate to treat the above-mentioned patient(s) will use restorative, oral surgery, orthodontic, and patient management techniques that are reasonable, necessary and advisable.
I also authorize the administration of anesthetics or analgesics, which may be deemed advisable by Dr. Bonnin, Dr. Rachel, or Dr. Witcher.
I understand that the treatment plan to be presented, along with the fees outlined, could change depending upon the time elapsed since the initial examination and the extent of dental pathology. Furthermore, by signing this, I agree to be responsible for full payment of all charges for dental services performed on the above-named patient or patients.

I hereby authorize and consent to any treatment or procedure or the administration of necessary anesthetics which my child's dentist deems advisable in the diagnosis and/or treatment of this patient. By signing this medical authorization and consent, I understand that as a matter of law it shall be conclusively presumed:

A) That the action of my dentist in obtaining this consent from me was in accordance with an accepted standard of medical-dental practice among members of the medical-dental profession with similar training and experience in this or similar medical communities; and from information provided me by my dentist, I under these circumstances, have at least a general understanding of the procedures, the medically accepted alternate procedures or treatments and the substantial risks and hazards inherent in the proposed treatment or procedures which are recognized among dentists in this of a similar community who perform similar treatments or procedures; or

B) That I, considering all the surrounding circumstances, would have undergone such treatment or procedure had I been advised by my dentist as described in paragraph A above.

_____ _____
Signature of Authorized person on behalf of patient Date

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3201 East Olive Road, Suite B
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Rachel Witcher DMD & Board Certified Pediatric Dentist
Stu Bonnin DMD & Board Certified Pediatric Dentist
Edwin Witcher DMD, MS & Board-Eligible Orthodontist

CONSENT FOR DENTAL PHOTOGRAPHY AND SOCIAL MEDIA FORM

PATIENT CONSENT

I, _____

First name *Last name*

consent to dental images and / or video being made of me or my child / dependent. I agree that duplicates may be made for the referring doctor.

I agree that the images may be:
(Please check below to show consent)

	Yes	No
... placed in my dental record for future treatment	_____	_____
... electronically emailed to my treating health professional	_____	_____
... used by dental health professionals for education and training	_____	_____
... used in paper or electronic dental health publications	_____	_____
... used in commercial broadcast	_____	_____
... used in marketing materials (Facebook/Website)	_____	_____

By signing below, I confirm that I understand this consent form.

_____ _____

Signature of Authorized person on behalf of patient Date