Kids Smiles Children's Dental Office

Dear New Patient Parents:

Welcome to Kids Smiles! Thank you so much for coming in today. We hope you have an enjoyable visit. Kids Smiles was founded on Martin Luther King Jr. day in 2001. We are not-for-profit organization that treats children 1-15.

We would like to share our office procedures with you for today and all of our future visits. For your benefit, we will coordinate all primary insurance payments. All you need to do is inform us of the insurance that your child has and we will discuss the policy. If you have any questions about your insurance we will be more than happy to answer them to the best of our ability.

As a courtesy to you we offer specific appointment times for your child to be seen. We will try as hard as possible to make sure your child is seen in a reasonable amount of time. Due to the high demand of early morning, afternoon, and evening appointments, the wait may be a little longer at these times. The best time to be seen and leave quickly is the first appointment of the day, noon, or just after lunch. You may request these appointments if you prefer.

Because of the high demand for appointments and appointment times:

- If you are late you may be asked to reschedule.
- **Kids Smiles has a 24 hour 25 dollar administrative broken appointment fee. You must cancel at least 24 hours before the appointment to avoid this fee.**
- Kids Smiles confirms patients two days before the appointment as a courtesy to you. If you receive a confirmation message please call us back to reconfirm the appointment. Please come to your appointment 5 minutes before the scheduled time.

  Because your child is under 18 you must be in the waiting area at all times; however, you may send a guardian over 18 years in place of yourself as long as you have signed our consent form. This form applies for all visits except for cleaning appointments.

We are looking forward to seeing your children as patients for years to come

I understand the policies listed above.
Parent or Guardian's Signature:_____

Philadelphia Department of Public Health (2009)
Information Sheet – Amalgam dental fillings containing mercury

The Philadelphia Department of Public Health has developed this information sheet pursuant to Section 1, Title 9, Chapter 9-3100 of the Philadelphia Code. Its purpose is to give you information about amalgam fillings that contain mercury and other dental filling options.
Your dentist's office should provide you with a copy of this sheet and answer any questions that you may have.

1. What is dental amalgam?

• Dental amalgam is the silver-colored material used to fill (restore) teeth that have cavities. It is one of several approved choices for filling cavities.
• Amalgam is made up of 50 percent mercury, a type of metal. Amalgam also contains other metals including silver, tin, copper, and zinc.

2. Is dental amalgam that contains mercury safe?

• There is ongoing research and discussion about the health effects of mercury in amalgam fillings.
• Small amounts of mercury are released as a vapor (gas) when amalgam fillings are placed or removed and through chewing. This mercury can be absorbed by the body and may build up over time.
• High levels of mercury can cause toxic effects on the brain, nervous system, and kidneys.
• Generally, people with amalgam fillings have higher levels of mercury in their blood and urine than people without amalgam fillings. The mercury levels in people with amalgam fillings are not high enough to be considered toxic.
• So far, well-done studies have shown that amalgam fillings do not impact behavior, information processing, and kidney function among children.
• It is more difficult to study the long-term effects of dental amalgam (effects that may appear later in life). Research in this area is still being performed.
• The Food and Drug Administration (FDA), which regulates the safety of medications and medical devices, has stated that "dental amalgams contain mercury, which may have neurotoxic effects on the nervous systems of developing children and fetuses." The FDA is currently reviewing data and will make a decision about how strongly to regulate the use of amalgam.

3. Are there alternatives to amalgam?

• Yes. Amalgam is one of several approved choices for filling cavities.
• The most common dental filling used today is resin composite, which does not contain mercury. Resin is usually tooth-colored.
• Other filling materials are a form of glass cement, porcelain, gold, and other metals.

4. Aside from safety issues, what are the pros and cons of amalgam and alternatives?

• Amalgam fillings generally last longer than resin composite fillings, so they don't need to be replaced as often.
• Resin composite fillings are tooth-colored and, therefore, are preferred by some people for cosmetic reasons.
• There may be a cost difference between resin composite and dental amalgam.
• To protect the environment, amalgam must be disposed of as a hazardous waste.

5. What should you do?

• Talk to your dentist, ask questions, and make an informed choice about dental fillings if you have a cavity.
• Prevent cavities through regular brushing, flossing, and dental exams.
• For more information on amalgam fillings that contain mercury:

The U.S. Food and Drug Administration Questions and Answers on Dental Amalgam:
www.fda.gov/cdrh/consumer/amalgams.html
Centers for Disease Control Dental Amalgam Use and Benefits Fact Sheet:
http://www.cdc.gov/oralHealth/publications/factsheets/amalgam.htm
or call toll-free:
The U.S. Food and Drug Administration at
1-800-638-2041 (option #2) between 8:00 a.m. and 4:30 p.m

A copy of this information sheet has been provided to the patient (or patient's representative) and his/her questions, if any, have been answered.

Parent(s)/Guardian(s) signature_____ Date_____

Dentist signature_____ Date

KIDSSMILES

CONSENT OF FINANCIAL RESPONSIBILITY

Even though we will check with your insurance company to determine if you need to have prior authorization, a second opinion, or whether you have any significant deductibles or co-payments to pay, ultimately you are responsible for any specific policies or penalties required by your insurance plan. You should double check with your insurance company to see if your plan has any conditions you need to know about.

In the event the service is not covered by your insurance company, you are financially responsible for the services provided.

If your insurance company does not pay the entire bill, we will send you a statement to notify you of any remaining unpaid balances. Whatever your insurance company does not pay is your responsibility. We will not send you a statement until your primary insurance company has fulfilled its financial responsibility. This statement will usually come within 45 days after you have been to the hospital or clinic, unless there is a delay in your insurance's payment. Major credit cards (Visa, Mastercard), debit cards (Visa, Mastercard), cash and mailed in checks are accepted methods of payment for your portion of the bill. If you have problems with your portion of your bill, please let us know. We can help you to arrange types of payment plans available for you.

Parents/Guardian Date

_____ _____

KidsSmiles
Dental Care for All our Children

Welcome to Kids Smiles

We would like to welcome your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime!

Child's Information

Today's Date: _____

Child's Name: _____
Last First MI

Child's Nickname: _____

Child's Age: _____ ☐ Male ☐ Female

Child's Birthdate: _____/_____/_____ S.S. # _____

School: _____ Grade: _____

Child's Home Phone Number: ( ) _____

Child's Home Address: _____
Street Apt/Condo#

_____
City State Zip Code

General Information

Who is accompanying the child today?

Name: _____ Relation: _____

Do you have custody of this child or are you the guardian?

☐ Yes ☐ No

Whom may we Thank for referring you: _____

Parent's Information

Who is responsible for the account? _____

Parent/Guardian's Name: _____

Parent's Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Partnered ☐ Separated ☐ Widowed

Parent's Birthdate: _____/_____/_____ S.S. # _____

Home Phone Number: ( ) _____

Cell Phone Number: ( ) _____

Address (if different from child's): _____
Street Apt/Condo#

_____
City State Zip Code

Email Address: _____

Employer: _____

Work Phone Number: ( ) _____ Ext. _____

If you have dental insurance coverage for the child, please fill out below.

Insurance Company Name: _____

Policy Holder's Name: _____

Policy Holder's S.S. # _____

Emergency Contact Information

Name: _____ Phone Number: ( ) _____

Address: _____
Street Apt/Condo# City State Zip Code

Release Information

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Parent's Signature Date

Parent Permission Policy

I give Kids Smiles permission to see my child(ren) in my absence. I understand that this consent consists of any treatment not limited to but including fillings, sealants, nerve treatments, and children's crowns/ caps. In order to complete treatment, topical and/or local anesthetic may be used, and my child's hands may need to be restrained.

As my child is a minor, I understand that someone over the age of 18 must accompany my child(ren) to the office and remain there for the duration of their appointment. I give consent for that person to make any decision concerning my child's treatment.

I understand that a parent or legal guardian must be present at their initial and six-month visits in order to present and update treatment plans for my child to be seen.

I also consent to my child's name and birth date being placed on the outside of their chart. I understand that Kids Smiles will keep this information as private as possible.

_____
Parent's Signature Date

Dental & Medical History

Tell us why you brought the child to the dentist today: _____

_____

_____

Has the child ever taken any diet pills such as Phen-fen (also known as Redux or Pondimin)? ☐ Yes ☐ No

If so, when? _____

Is the child currently in pain? ☐ Yes ☐ No

Does the child need antibiotics before dental treatment? ☐ Yes ☐ No

If yes, why? _____

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

Is the child's water flouridated? ☐ Yes ☐ No

Is the child taking flouridated supplements? ☐ Yes ☐ No

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

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

Does the child floss his/her teeth daily? ☐ Yes ☐ No

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

Child's Physician: _____

Phone Number: ( ) _____ _____
Date of last visit

Previous/Present Dentist: _____

Phone Number: ( ) _____ _____
Date of last visit

How would you describe the child's current physical health? ☐ Good ☐ Fair ☐ Poor

Please list all prescription/over the counter or herbal supplement drugs that the child is currently taking:

_____

_____

Aside from the items below, list all other drugs/things that the child is allergic to:

_____

Latex ☐ Yes ☐ No **Nickel/Metals** ☐ Yes ☐ No

Plastic ☐ Yes ☐ No **Nut/Tree nut/Peanut** ☐ Yes ☐ No

Dental & Medical History Continued...

Has the child experienced the following medical problems?

ADD/ADHD	☐ Yes ☐ No	Abnormal Bleeding / Hemophilla	☐ Yes ☐ No
AIDS/HIV+	☐ Yes ☐ No	Artificial Bones / Joints / Valves	☐ Yes ☐ No
Anemia	☐ Yes ☐ No	Congenital Heart Defect	☐ Yes ☐ No
Asthma	☐ Yes ☐ No	Handicaps or Disabilities	☐ Yes ☐ No
Autism	☐ Yes ☐ No	Developement Issues	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Kidney or Liver problems	☐ Yes ☐ No
Chicken Pox	☐ Yes ☐ No	Mitral Valve Prolapse	☐ Yes ☐ No
Convulsions	☐ Yes ☐ No	High Blood Pressure	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	Low Blood Pressure	☐ Yes ☐ No
Epilepsy	☐ Yes ☐ No		
Heart Murmur	☐ Yes ☐ No		
Hepatitis	☐ Yes ☐ No		
Hives	☐ Yes ☐ No		
Lupus	☐ Yes ☐ No		
Measles	☐ Yes ☐ No		
Mononucleosis	☐ Yes ☐ No		
Prosthetics	☐ Yes ☐ No		
Rheumatic Fever	☐ Yes ☐ No		
Scarlet Fever	☐ Yes ☐ No		
Sickle Cell Disease	☐ Yes ☐ No		
Skin Rash	☐ Yes ☐ No		
Tuberculosis (TB)	☐ Yes ☐ No		
Born Prematurely	☐ Yes ☐ No		

If yes, at what week? _____

Are child's immunizations current? ☐ Yes ☐ No

Had any hospital stays / operations ☐ Yes ☐ No *If yes, when & why?*

_____

_____

_____

Is there anything you would like to discuss with the doctor in private? ☐ Yes ☐ No

Did the child experience any of the following? (check all that apply)

- ☐ Breast Fed
- ☐ Chewing on Objects
- ☐ Clenching / Grinding Teeth
- ☐ Lip Sucking / Biting
- ☐ Mouth Breather
- ☐ Nail Biting
- ☐ Nusing Bottle Habits
- ☐ Speech Problems
- ☐ Thumb / Finger Sucking
- ☐ Tongue / Cheek Biting
- ☐ Tongue Thrust
- ☐ Used a Pacifier

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

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest 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.

_____
Parent's Signature Date

OFFICE USE ONLY

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

_____
Dentist's Signature Date

Dentist's Comments: _____

_____

_____

Clearance required? ☐ Yes ☐ No

Medical History Update

Has there been any change in the child's health status since their last visit? If so, please explain. Be sure to include new medication(s) or discontinued medication(s).

_____
Signature of Parent or Guardian Date

_____
Signature of Parent or Guardian Date

Has there been any change in the child's health status since their last visit? If so, please explain. Be sure to include new medication(s) or discontinued medication(s).

_____
Signature of Parent or Guardian Date

_____
Signature of Parent or Guardian Date