Jason C. Barb, DDS

John M. Venzel, DMD

Patient Profile Form

Please complete all information, and bring it with you on your first visit to our office. Please Note: We *do not* file Third Insurances.

Child's Information

Child's Name _____
Last First MI

Nickname_____ ❒ Male ❒ Female

Siblings that we treat_____

Child's Birthdate____/____/____ Child's Age_____

SS # _____

Child's Home #(_____) _____

Child's Home Address_____
Apt./Condo #

_____
City State Zip

Who does the child live with?

❒ Mother ❒ Father ❒ Guardian* ❒ Foster Parent*

*Guardians and Foster Parents must provide legal custody documentation at child's 1st appointment.

Mother's Information

Name _____
Last First MI

DOB___/___/_____

Home Address (if different)_____
Apt./Condo #

_____
City State Zip

Employer_____

Home #(_____) _____

Cell #(_____) _____

Email_____

SS # _____DL#_____

Marital Status

❒ Single ❒ Married ❒ Separated ❒ Widowed ❒ Divorced

Father's Information

Name _____
Last First MI

DOB___/___/_____

Home Address (if different)_____
Apt./Condo #

_____
City State Zip

Employer_____

Home #(_____) _____

Cell #(_____) _____

Email_____

SS # _____DL#_____

Marital Status

❒ Single ❒ Married ❒ Separated ❒ Widowed ❒ Divorced

Custodial Consent for Minor's Treatment

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

Is there a custody/parenting agreement? ❒ Yes ❒ No

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

To ensure the safety and security of our patients, Guardians and Foster Parents must provide legal custody documentation at child's 1st appointment.

Primary Dental Insurance

Please Note: The parent who's birthday falls first in the year is primary.

Insurance Co. Name _____

Insurance Co. Address_____
Suite #

_____
City State Zip

Insurance Co. Phone #(_____) _____

Member ID #_____

Group # (Plan, Local or Policy #)_____

Policy Owner's Name_____

Relationship to Patient_____

Policy Owner's Birthdate_____/_____/_____

SS #_____

Policy Owner's Employer_____

Secondary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address_____
Suite #

_____
City State Zip

Insurance Co. Phone #(_____) _____

Member ID #_____

Group # (Plan, Local or Policy #)_____

Policy Owner's Name_____

Relationship to Patient_____

Policy Owner's Birthdate_____/_____/_____

SS #_____

Policy Owner's Employer_____

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Patient Name:_____ **Birthdate:** ____/____/____

Dental History

Is this your child's first dental visit? Yes No

If not, last visit date?_____

Were any x-rays taken at previous visits? Yes No

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

If yes, please explain._____

_____

_____

Why did you bring your child to the dentist today?_____

_____

_____

Does the child have any of the following habits?

Y / N Nursing Bottle Habits Y / N Lip Sucking/Biting

Y / N Thumb/Finger Sucking/Pacifier Y / N Nail Biting

Has the child ever had a serious or difficult circumstance associated with previous dental work? If yes, please explain.

_____

_____

_____

Is the child's water fluoridated? Yes No

Does the child brush teeth daily? Yes No

Does the child floss daily? Yes No

Has the child ever had any pain in jaw? Yes No

Does the child play sports? Yes No

Is the child currently under the care of a physician for a chronic condition? If yes, please explain.

_____

_____

Health History

Has the child ever had any of the following?

Y / N	Allergies to drugs	Y / N	Hepatitis
Y / N	Abnormal bleeding	Y / N	HIV+/AIDS
Y / N	Hemophilia	Y / N	ADD/ADHD
Y / N	Asthma	Y / N	Food Allergies
Y / N	Seizures/Epilepsy	Y / N	Sleep apnea
Y / N	Congenital Heart Disease	Y / N	Any hospital stays
Y / N	Heart murmur	Y / N	Any operations
Y / N	Handicaps/disabilities	Y / N	Hearing impairment
Y / N	Autism/Asperger's	Y / N	Pregnancy
Y / N	Kidney/liver problems	Y / N	Cancer
Y / N	Allergy to latex products	Y / N	Diabetes

If answered yes above, please explain 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 #(_____)_____

Who may we thank for referring you to our office?_____

I understand that the above information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence in accordance with the HIPAA Notice of Privacy Practices and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental team to perform the necessary dental services my child may need. I hereby authorize my insurance benefits to be paid to the undersigned dentist. I acknowledge that I am financially responsible for any unpaid balance. If any balance is overdue and legal assistance becomes necessary, the responsible party will be liable for all charges incurred.

_____ _____ _____

Signature of Parent or Legal Guardian Date Relationship to Patient

Kidsmile, Inc. Office Policies

We are committed to providing our patients with leading edge dental technologies, and helping your child maintain optimal oral health. Toward these goals, we would like to explain your financial and scheduling responsibilities with Kidsmile, Inc.:

Payment: Payment is due at the time services are rendered. We accept all major credit cards and offer Care Credit Financing. The party presenting the child for treatment will become the party held financially responsible. Exceptions will not be made. In addition, we reserve the right to not schedule any further appointments in the event your account is 90 days past due from receiving a billing statement.

Dental Benefit Plans: Your dental benefits are a contract between you or your employer and the dental insurance company. The benefits you receive are based on the terms of the contract negotiated between you or your employer and the dental insurance company, not our dental office. Our office will do everything possible to help you understand and maximize your dental coverage. Please be aware that our office will not bill a private third party for your child's dental care.

If we are a contracted provider with your dental plan, you are responsible only for the portion of the approved fees as determined by your plan. We are required to collect the patient's portion deductible, co-pay or any amount not covered by the dental plan in full at the time of service. As a **courtesy** to our patients, we will file your dental insurance claims and bill your dental insurance company for the treatment your child receives. However, in the event the insurance company, for any reason does not pay the estimated portion of the bill, the balance will become the patient's responsibility and will be billed directly to you.

If we are NOT a contracted provider with your dental plan, it is the patient's responsibility to verify with the plan whether the plan allows patients to receive reimbursement for services from out-of-network providers. If your plan allows reimbursement from out-of-network providers, our practice can file the claim with your plan and receive reimbursement directly from the plan if you "assign benefits" to us. In this circumstance, you are responsible and will be billed for any unpaid balance for services rendered upon receipt of payment from the plan to our practice, even if the amount is different than our estimated patient portion of the bill. If you choose not to "assign benefits" to our practice, you are responsible for filing claims and obtaining reimbursement directly from your dental plan and are responsible for payment to our practice at the time of service.

Scheduling of Appointments: Our patient schedule is guided by the age and dental needs of your child. We reserve the doctor's and hygienist's time on the schedule for each patient and are diligent about being on-time. To maintain the utmost service and care, **we require a 24-hour notice to re-schedule an appointment**. We reserve the right to reschedule patients who arrive late for their scheduled appointment. In the event our office is unable to confirm your appointment or insurance, your appointment may be canceled. In addition, we reserve the right to dismiss a patient from our practice for repeated missed appointments.

It is the parent/legal guardian's responsibility to notify us of any change in address, telephone, email or insurance information in order for us to maintain accurate records.

By signing below, I acknowledge that I have read and agree to the financial and scheduling terms above. I also acknowledge that a copy of this practice's Notice of Privacy Practices has been made available to me, and any questions answered regarding the Notice.

_____ _____

Signature of Parent /Legal Guardian Date

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