Kool Koala Pediatric & Adolescent Dentistry

501 Whitehorse Pike
Collingswood, NJ 08107
Phone: (856) 854-1509

1692 Clements Bridge Rd.
Deptford, NJ 08096
Phone: (856) 845-6198

Patient

Name:	**DOB:**	**SSN:**	
Address:	**City:**	**State:**	**Zip:**
Phone: ( )	**Email:**		
Patient Lives With: Mother Father Other: _____	Siblings that we treat:		

Responsible Party

Name of Parent(s) / Legal Guardian(s)		**DOB:**	**SSN:**
Primary Phone: ( ) House/Cell/Work/Other **Secondary Phone: ( )** House/Cell/Work/Other		**Name of Employer:**	
Emergency Contact 1:	Relation:	Phone: ( )	
Emergency Contact 2:	Relation:	Phone: ( )	
Who is accompanying the patient today? (If other than Parent/Legal Guardian please see Front Desk for further release forms)			

Primary Insurance

Insurance Company Name:	**Insurance ID #:** **Group #:**	
Policy Holder's Name:	**DOB:**	**SSN:**
Relationship to Patient:	**Employer:**	

Secondary Insurance

Insurance Company Name:	**Insurance ID #:** **Group #:**	
Policy Holder's Name:	**DOB:**	**SSN:**
Relationship to Patient:	**Employer:**	

Dental History

Date of last dental visit:	**Were any X rays taken at previous dental visits?**
Have there been any injuries to the teeth, face or mouth:	
Why did you bring the patient to the dentist today?	
Has the child had a serious or difficult problem associated with previous dental work?	

Please comment on the following:

Lip Sucking/Biting: ..... No Yes
Nursing/Bottle Habits: ..... No Yes
Nail Biting: ..... No Yes
Thumb/Finger Sucking: ..... No Yes

Is the patient's water fluoridated: .....No Yes
Is the patient taking fluoride supplements: ....No Yes
Does the patient brush teeth daily: .....No Yes
Does the patient floss teeth daily: ……No Yes

Medical History

Child's Allergies (include date noted if known):	**Please discuss any serious Medical conditions:**
Child's Medications (include dose if known):	
Please discuss any past hospitalizations or operations:	
Patient's Physician:	**Phone: ( )**

Has the patient ever had any of the following conditions:

Y N Heart disease / Murmur
Y N Diabetes
Y N Asthma
Y N Seizures
Y N Kidney / Liver problems
Y N High blood pressure
Y N Low blood pressure
Y N Heartburn (reflux)
Y N Abnormal bleeding
Y N Hemophilia
Y N Lung problems
Y N Sinus problems
Y N Hearing impairment
Y N Pain in jaw (TMJ/TMD)
Y N Cancer
Y N Hepatitis
Y N Autism Spectrum Disorder
Y N ADD/ADHD
Y N Developmental delays
Y N Tuberculosis
Y N Pregnancy
Y N Congenital Birth Defects
Y N HIV/AIDS
Y N Rheumatic/Scarlet Fever
Y N Latex allergy
Y N Penicillin allergy
Y N Amoxicillin allergy

I understand that the information I have given is correct to the best of my knowledge, that 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 that my child may need.

_____ _____

Signature of Parent or Guardian Date Relationship to Patient

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CONSENT FOR DENTAL TREATMENT

I request and authorize Dr. Ballard and his staff to examine, clean and (after signed treatment plan and consultation) provide my child with comprehensive dental treatment including fillings, crowns, extractions and nitrous oxide, if required. I further request and authorize the taking of dental x-rays as may be considered necessary by Dr. Ballard to diagnose and/or treat my child's dental condition. I will allow photographs to be taken of my child and/or my child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Ballard provides an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I understand that I will be responsible for any charges incurred on this child for dental treatment.

Signature: _____

Date: _____

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FINANCIAL POLICY

Please be aware that the parent bringing the child to our office is responsible for payment of all charges. We cannot send statements to other persons. If you have been referred by a general dentist, we ask that you pay the cost of the initial examination and any necessary dental x-rays on the day of the appointment. Please understand that financial arrangements are made directly with you. For the convenience of our patients, the following outlines our financial policies:

1. **Payment is Due in Full For Each Appointment As Services Are Rendered**: At our office location we accept cash, MasterCard, Visa, American Express and Discover. We also accept Care Credit. If checks are mailed in for payment, a charge of $50.00 will be assessed on the checks returned for any reason. You will be responsible for payment of all cost and fees incurred, including attorney's fees, should collection efforts be made in order to fulfill a debt.

2. **Dental Insurance**: The type of plan chosen by you and/or your employer determines your insurance benefits. As such, we have NO say in the selection of your insurance company, we have NO control over the terms of your contract, the method of reimbursement or the determination of your insurance benefits.

3. **Pre-treatment Authorization**: Some insurance companies recommend and s=estimate of the work to be done and the fees to be charged before determining their benefits to you. If so, we will provide you with the pre-treatment fee estimate. In this case, it will be up to you to determine if you wish to proceed with the treatment before the insurance benefit is determined.

4. **Fillings**: Our dental material of choice is a white (composite resin) filling. Please be aware that your insurance company may not pay for a resin filling at the same level as a silver (amalgam filling). The co-payment is your responsibility. In some cases, the dentist may recommend placing a silver crown instead of resin filling.

5. **Nitrous Oxide**: Nitrous Oxide is not usually covered by dental insurance. We thank you for you payment the date of service.

6. **Ortho-Appliances**: The entire coat of the appliance must be paid on the day your child's impressions are taken. This is necessary because our office must pay the laboratory bills when appliances are ordered, not when they are completed.

7. **Emergency Treatment**: All emergency treatment must be paid in full at the time the service is rendered.

8. **Fluoride**: The American Dental Association recommends fluoride treatments 2x's per year However, your insurance company may cover 1x per year. Please reference your selected plans guidelines.

Please remember, even if you have insurance coverage, ***you are responsible for payment of your account****. Please realize that your insurance coverage is a relationship between you, the insured patient, and your insurance company. Your understanding and cooperation with this matter is greatly appreciated. You are helping us keep our overhead expenses, in the form of direct and labor costs, down. In addition, you are helping keep your fees as low as possible. Past due accounts are subject to a monthly service charge and will be turned over for collection by an outside agency. You agree to pay any and all attorney fees associated with the collection of monies due.* ***I have read and understand my obligation****.*

Signature: _____ Date: _____

I authorize my insurance to pay directly to my dentist. Our office is in a network provider for Delta Premier and Delta Dental PPO; but our office will try to assist you with filing to most major PPO insurance companies. It is at Kool Koala Pediatric & Adolescent Dentistry's discretion as to which policies we will file for. I authorize my insurance company to pay directly to my dentist as an assignment of benefit for treatment rendered. If I am covered by any other plan, I will pay in full when services are rendered. I understand that all policies are different and I am responsible for knowing my plan provisions. I understand I will be responsible for all co-payment, deductible, and rejected charges.

Signature: _____ Date: _____

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NOTICE OF PRIVACY PRACTICES - HIPPA

Disclosure of Health Information

We use and disclose health information about your child for treatment, payment, and healthcare operations. We may disclose your child's information to a healthcare provider treating him/her. You may give us written authorization to disclose health information to anyone for any purpose. This may be revoked in writing. We need written permission before any health information is disclosed to any caregivers besides the child's legal guardian. In the event of an emergency we will disclose information based on our professional judgment. We may use your child's health information to obtain payment for services. We will not use health information for marketing purposes. If we suspect a possible victim of abuse, neglect, or domestic violence we may disclose your child's health information as the law requires. We may disclose your child's health information to provide you with appointment reminders or treatment recommendations (such as voicemails, postcards, emails or letters).

Patients' Rights

Access: You have the right to look at or get copies of your health information. If you request copies we will charge you for each page for staff time to locate and copy the information, and postage if you want the copies mailed.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of information.

Alternative Communication: You have the right to request that we communicate with you about your health history in alternative means Amendment: You have the right to request that we amend your health information. We may deny your request under certain circumstances.

Questions and Complaints

If you are concerned that we may have violated your privacy rights, or disagree with a decision we made about access to your health information or in response to a request to amend or restrict the disclosure of health information you may submit a written complaint to the US Department of Health and Human Services.

If you have any further questions about our privacy practices please contact Dr. White.

Signature: Date:

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We have more patients who need dental care than we have room in our daily schedule to provide. When a patient does not show up for their appointment or cancels too close to their scheduled time, we are unable to fill this appointment time with another patient who desperately needs dental care. This policy is our attempt to ensure that both you and our other patients receive the dental care that you need.

- Any appointments cancelled, missed, or rescheduled with less than 24 hours' notice will be considered "Broken Appointments." These will receive a $25 fee.
- This fee is not covered by your insurance, and payment will be required at the next appointment.
- After 3 broken appointments, our office reserves the right to only schedule "same day appointments".
- It is your responsibility to confirm your appointment and to update us with new contact information. The office reserves the right to remove any patient from the schedule after 3 unsuccessful attempts have been made to reach you for confirmation.

Patients who have broken three or more appointments with us can either call us in the morning for a "same day appointment". If a spot has become available, we will be able to add you to that day's schedule. But please understand there is no guarantee that you will receive an appointment as a "walk-in."

I (Parent/Guardian) _____, understand and accept the cancellation policy at this time.

Parent Signature: _____

Patient's Name_____ Date:_____