Kruckman FAMILY DENTISTRY

Child Pre-Clinical History

Date:_____

Child's Name:_____ ❑ Male ❑ Female

Preferred Name: _____

Address: _____

City:_____ State: _____ Zip:_____

Homephone: _____ Cell phone:_____

School: _____ Grade: _____

Date of Birth: ____ /____ /_____ Age: _____

Names/ages of brothers/sisters:_____

_____

Is this your child's first dental experience? ❑ yes ❑ no

What is your child's attitude toward this visit? _____

_____

Whom may we thank for referring you to our office?: _____

EMERGENCY INFORMATION

Person to contact: _____

Relationship:_____ Phone: _____

❑ I give permission for Kruckman Family Dentistry to share my medical & account information with:_____

DENTAL INSURANCE INFORMATION

Name of Primary Insurance Company: _____

Address: _____

Phone: _____

Name of policy holder: _____

Relationship to policy holder: ❑ Self ❑ Spouse ❑ Child ❑ Other_____

Policy holder's ID/social security #: _____

Group #:_____Policy holder's birth date: ____/____/____

Policy holder's employer: _____

Name of Secondary Insurance Company: _____

Address: _____

Phone: _____

Name of policy holder: _____

Relationship to policy holder: ❑ Self ❑ Spouse ❑ Child ❑ Other_____

Policy holder's ID/social security #: _____

Group #:_____Policy holder's birth date: ____/____/____

Policy holder's employer: _____

DENTAL HISTORY

Reason for today's visit:_____
_____
_____
Former Dentist:_____
_____
City/State_____
Date of last dental visit?_____
Date of last dental x-rays?_____

Place a mark on **"Yes"** or **"No"** to indicate if you have any of the following:

Bad Breath.....❑Yes ❑No
Bleeding Gums.....❑Yes ❑No
Blisters on Lips or Mouth.....❑Yes ❑No
Food Collection Between the Teeth.....❑Yes ❑No
Grinding Teeth.....❑Yes ❑No
Gums Swollen or Tender.....❑Yes ❑No
Jaw Pain or Tiredness.....❑Yes ❑No
Lip or Cheek Biting.....❑Yes ❑No
Loose Teeth or Broken Fillings.....❑Yes ❑No
Mouth Breathing.....❑Yes ❑No
Mouth Pain, Brushing.....❑Yes ❑No
Orthodontic Treatment.....❑Yes ❑No
Previous Dental Visits Been Good?.....❑Yes ❑No
Sensitivity to Cold.....❑Yes ❑No
Sensitivity to Heat.....❑Yes ❑No
Sensitivity to Sweets.....❑Yes ❑No
Sensitivity when Biting.....❑Yes ❑No
Sores or Growths in your Mouth.....❑Yes ❑No
Suck Thumb/Fingers/Pacifier.....❑Yes ❑No
How Much Soda do you Drink?_____
How Often do you Floss?_____
How Often do you Brush?_____

HEALTH HISTORY

Physician's Name: _____Date of last visit: _____ Phone _____
Are you currently being treated by a physician? Explain: _____
Have you had any serious health problems in the last five years? Explain _____

Do you have, or have you had, any of the following?

ADHD/ADD.....❑Yes ❑No
AIDS.....❑Yes ❑No
Anemia.....❑Yes ❑No
Artificial Heart Valve.....❑Yes ❑No
Artificial Joints.....❑Yes ❑No
Aspergers/Autism.....❑Yes ❑No
Asthma.....❑Yes ❑No
Bleeding Abnormally, with Extractions or Surgery.....❑Yes ❑No
Blood Disease.....❑Yes ❑No
Bruise Easy.....❑Yes ❑No
Cancer.....❑Yes ❑No
Cerebral Palsy.....❑Yes ❑No
Chemotherapy.....❑Yes ❑No
Circulatory Problems.....❑Yes ❑No
Congenital Heart Disorder.....❑Yes ❑No
Cortisone Treatments.....❑Yes ❑No
Cough, Persistent or Bloody.....❑Yes ❑No
Diabetes.....❑Yes ❑No
Epilepsy or Seizures.....❑Yes ❑No
Glaucoma.....❑Yes ❑No
Headaches.....❑Yes ❑No
Heart Murmur.....❑Yes ❑No
Heart Problems/Disease.....❑Yes ❑No
Type_____
Hepatitis...Type_____.....❑Yes ❑No
Herpes.....Type_____.....❑Yes ❑No
HIV Positive.....❑Yes ❑No
Jaundice.....❑Yes ❑No
Jaw Pain.....❑Yes ❑No
Kidney Disease.....❑Yes ❑No
Liver Disease.....❑Yes ❑No
Low Blood Pressure.....❑Yes ❑No
Mental Health Disorder.....❑Yes ❑No
Mitral Valve Prolapse.....❑Yes ❑No
Nervous Problems.....❑Yes ❑No
Pacemaker.....❑Yes ❑No
Radiation Treatment.....❑Yes ❑No
Respiratory Disease.....❑Yes ❑No
Rheumatic Fever.....❑Yes ❑No
Scarlet Fever.....❑Yes ❑No
Sensory Disorder.....❑Yes ❑No
Sinus Trouble.....❑Yes ❑No
Skin Rash.....❑Yes ❑No
Special Diet.....❑Yes ❑No
Speech Disorder.....❑Yes ❑No
Stroke.....❑Yes ❑No
Swelling of Feet/Ankles.....❑Yes ❑No
Swollen Neck Glands.....❑Yes ❑No
Thyroid Problems.....❑Yes ❑No
Tonsillitis.....❑Yes ❑No
Tuberculosis.....❑Yes ❑No
Tumor or Growth on Head or Neck.....❑Yes ❑No
Ulcer.....❑Yes ❑No Type_____
Weight Loss, Unexplained.....❑Yes ❑No
Dental Anxiety.....❑Yes ❑No
Other (describe)_____
_____

MEDICATIONS

List medications you are currently taking and why you are taking them _____
_____
_____
Do you need to take an antibiotic prior to dental appt? _____
Pharmacy Name:_____ Phone:_____

ALLERGIES

❑Aspirin
❑Barbiturates (Sleeping Pills)
❑Codeine
❑Iodine or Shellfish
❑Latex
❑Local Anesthetic
❑Penicillin/Other Antibiotics
❑Sulfa Drugs
❑Other: _____
_____

When a health care worker is exposed to my blood or body fluids through a needle stick, cut or splash to the eye or mouth, I agree to have my blood tested for blood-borne diseases to include Hepatitis B and C Virus and Human Immunodeficiency Virus (AIDS). ***Initials:*** _____
The information I have given is true and accurate to the best of my knowledge.

Parent Signature _____ ***Date*** _____

Financial Agreement

It is our goal for our patients to understand their treatment needs as well as their financial responsibility before treatment begins. It is our desire to make dental treatment affordable to all of our patients. Please review the following policies and procedures:

Payment Policy: Payment is due at the time services are rendered. If you have dental insurance, your estimated co-pay plus deductible is due at the time of service. If no insurance is involved, payment is expected at each visit.

1. We accept cash, personal checks with proper ID, Debit Cards, Visa, MasterCard, Discover, and American Express.

2. If there is an unpaid balance over 90 days, additional charges may apply.

3. You will be responsible for any and all costs incurred in the collection of your debt (i.e. collection agency fees, court fees and/or attorney fees).

4. Financing available through Care Credit with prior approval.

5. Fees, $40.00, will apply for any check that is returned by the bank.

6. MINOR PATIENTS: In the case of divorced or separated parents, it is **YOUR** responsibility to have financial arrangements made according to the divorce decree before treatment begins.

Dental Insurance

As a courtesy to you we will gladly process your insurance claim forms. Our responsibility is to provide you with the treatment that best meets your needs, not to try to match your care to insurance plan limitations. Dental insurance plans do not correspond to individual patient needs, and as such, many routine and necessary dental services are not covered even though you may need those services.

We understand insurance guidelines can be hard to understand and overwhelming at times. Fortunately with the information provided to us by you and your insurance company we are able to provide some assistance in estimating your insurance benefit. However, your insurance company makes final determination once treatment is completed and the claim is submitted. Your insurance is a contract between you and your insurance company; therefore, all charges are your responsibility.

All insurance benefits are payable to the dental office, and I agree to release any information necessary for the dental office to process claims.

Signature: _____

I realize I am financially responsible for all charges incurred, regardless of insurance coverage. I am aware past due accounts will be subject to a charge of 1.5% per month interest. I am responsible for all collection costs incurred by Kruckman Family Dentistry.

Initials: _____

Appointment Cancellation Policy

When you schedule an appointment, we reserve that time and prepare in anticipation of serving you. If you should need to reschedule, **we kindly request that you contact us by phone with advanced notice of two business days.** We understand that conflicts arise; however failing your appointment or canceling without adequate notice more than once will result in a **$50 charge for each hour of scheduled time and then discontinuation of services.** ***Initials:*** _____

I have read and understand this document in its entirety; outlining the office and financial policies of Kruckman Family Dentistry and agree to these terms.

Signature of patient or parent/guardian: _____ ***Date:*** _____

Kruckman
FAMILY DENTISTRY

Consent for Use & Disclosure of Health Information

Section A: Patient Giving Consent

Name:_____ Birth date: ____/____/____

Address:_____

Section B: Please read the following statement carefully.

Purpose of Consent: By signing this form, you are consenting to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosure we may make of your protected health information, and other important matters about your protected health information.

We reserve the right to change our Privacy Practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including and revisions of our Notice, at any time by contacting:

Shanna at Kruckman Family Dentistry, 576 Cherry Dr., Waconia, MN 55387, 952-679-4461

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of revocation, submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or continue treating you if you revoke this consent.

Section C: Signature

I have had full opportunity to read and consider the contents of this Consent Form and Notice of Privacy Practices. I understand that, by signing this Consent Form, I am giving my consent to your use and disclosure of my health information to carry out treatment, payment activities and health care operations.

X_____