WELCOME TO SEAHORSE KIDS DENTAL

Dentistry for Infants, Children and Adolescents

PATIENT INFORMATION

First Name _____ Last Name _____
Date of Birth _____ Age _____ ☐ Male ☐ Female
Address _____
City _____ State _____ Zip _____
School _____
How Did You Hear About Us?
☐ Website ☐ Google ☐ Yelp ☐ Facebook ☐ Mail Promotion
☐ Pediatrician _____ ☐ Friend _____
☐ Other _____

RESPONSIBLE PARTY INFORMATION

First Name _____ Last Name _____
Relationship to Patient _____
SSN _____ Driver's License/ID # _____
Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Domestic Partner
Address (If different) _____
City _____ State _____ Zip _____
Home Number _____
Cell Number _____
Email Address _____
Occupation _____
Work Number _____

WHO IS ACCOMPANYING THE PATIENT TODAY?

First Name _____ Last Name _____
Relationship to Patient _____
Do You Have Legal Custody of this Child? ☐ Yes ☐ No

EMERGENCY CONTACT

First Name _____ Last Name _____
Relationship to Patient _____
Address _____
City _____ State _____ Zip _____
Home Number _____
Cell Number _____

SERVICES

Here at Seahorse Kids Dental we have a variety of services available to improve your child's oral health. Please circle any services below that you would like our friendly staff to discuss with you during your visit.

Protective Sealants	Fluoride Treatments
Tooth Colored Fillings	Sedation
Tooth Colored Crowns	Orthodontic Screening

PRIMARY INSURANCE

☐ Insurance Card Provided

Insurance Company _____
Insurance Co. Phone _____
Insurance Co. Address _____
City _____ State _____ Zip _____
Policy# _____ Group # _____
Name of Policy Owner _____
Date of Birth _____ SSN _____
Subscriber Employer _____

SECONDARY INSURANCE

☐ Insurance Card Provided

Insurance Co. _____
Insurance Co. Phone _____
Insurance Co. Address _____
City _____ State _____ Zip _____
Policy# _____ Group # _____
Name of Policy Owner _____
Date of Birth _____ SSN _____
Subscriber Employer _____

PERSON RESPONSIBLE FOR ACCOUNT

First Name _____
Last Name _____
Relationship _____

Cell Phone & Message Consent
I consent to the dental practice using my cell phone number to CALL or TEXT regarding appointments, treatment, insurance and my account. I understand that I can withdraw my consent at any time. I understand brief messages from the dental practice may be left on my home or cell phone or with those who answer the phone at the number provided unless I have provided the practice with alternative instructions for communication.

Cell Phone Number _____ Initials _____

ASSIGNMENT AND RELEASE

I, the undersigned, certify that I (or my dependent) have insurance coverage and assign directly to Seahorse Kids Dental all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the release of all information necessary to secure the payments of benefits. I authorize the use of this signature on all insurance submissions.

Responsible Party Signature _____
Relationship _____ Date _____

CONSENT: I hereby authorize Seahorse Kids Dental to perform on my child recommended dental treatment mutually agreed upon by me, as presented in the treatment plan, including a clinical examination, necessary radiographs (x-rays), and a professional cleaning and fluoride treatment

Guardian Signature _____ Date _____

NEW PATIENT HEALTH INFORMATION

DENTAL HISTORY

Reason for Today's Visit? _____

Rate the child's current dental health? ☐ Good ☐ Fair ☐ Poor

Is the child currently in pain? ☐ Yes ☐ No

Has the child been to a dentist before? ☐ Yes ☐ No

Date of Last Dental Visit _____

Date of Last Dental X-rays _____

Previous Dentist _____

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

Is the child's toothpaste fluoridated? ☐ Yes ☐ No

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

Does the child use mouthwash? ☐ Yes ☐ No

Do you brush the child's teeth? ☐ Yes ☐ No

Experience frequent canker sores? ☐ Yes ☐ No

How many snacks between meals per day? _____

Breast Feeding-Until Age _____ Bottle Feeding-Until Age _____

Is there anything about your child's smile that you would like to change?

_____

Does your child frequently consume? (*Circle all that apply*)

Fruit Juice	Chocolate Milk	Tap Water
Candy	Gummy Vitamins	Bottled Water
Fruit	Milk Before Bed	High Carb Snacks

Does the Child Have Any of the Following Habits? (*Circle all that apply*)

Use Pacifier	Suck Thumb/Finger	Clench/Grind Teeth
Chew Ice	Bite/Chew Nails or Lips	Mouth Breathing

Are you happy with the child's prior dental experiences? ☐ Yes ☐ No

Has the child had a previous unfavorable or fearful dental or medical experience? ☐ Yes ☐ No

If Yes, please describe _____

Describe your child's temperament _____

Name one thing he/she really likes _____

PHYSICIAN INFORMATION

Pediatrician/Physician Name _____

Address _____

Phone _____ Date of Last Visit _____

HEALTH HISTORY

YES	NO	CONDITIONS
☐	☐	Are immunizations current?

Has your child been diagnosed and/or treated for any of the following?

☐	☐	Abnormal Bleeding/Hemophilia
☐	☐	ADD/ADHD
☐	☐	Seasonal Allergies or Hay Fever
☐	☐	Asthma/Reactive Airway Disease
☐	☐	Autism/ASD
☐	☐	Bone/Joint Problems
☐	☐	Cancer/Tumor/Leukemia
☐	☐	Cleft Lip and/or Palate
☐	☐	Congenital Heart Defect
☐	☐	Diabetes
☐	☐	Disabilities/Special Needs
☐	☐	Hearing/Vision Impairment
☐	☐	Heart Disease/Murmur
☐	☐	HIV+/AIDS/Immune Disorder
☐	☐	Kidney/Liver Problems
☐	☐	Psychiatric/Mental Health
☐	☐	Rheumatic/Scarlet Fever
☐	☐	Sickle Cell Disease/Trait
☐	☐	Seizures/Epilepsy/Convulsions
☐	☐	Stomach/GI Disorders
☐	☐	Tuberculosis

YES	NO	Does the child have a history of the following?
☐	☐	Premature Birth
☐	☐	Serious Illness
☐	☐	Hospitalization/Surgery
☐	☐	Allergies to Medications/Foods/Materials

If Yes, please describe _____

_____

List Allergies _____

List Current Medications _____

I hereby certify that I have read the foregoing, that the information that I have given is correct to the best of my knowledge. I understand that this information will be held in the strictest confidence and it is my responsibility to inform this office of changes to the child's medical status. **I grant this office permission to do x-rays, examination** and dental services deemed necessary for my child.

Name of Parent/Guardian _____ Signature _____ Date _____

Doctor Signature _____ Date _____

CONSENT FORM

FINANCIAL POLICIES

Accepted Payment Methods
We accept Cash, most major credit cards and checks up to $200. There is a $50 insufficient funds charge on any returned check or invalid credit card payment.

Financing
We understand that necessary dental treatment is not always planned for in the budget. We will help you apply for Care Credit, which helps you pay for out-of-pocket healthcare expenses not covered by insurance. The parent or legal guardian of the patient will fill out a short application for approval. The third-party loan does not affect the responsible person's obligations under this agreement. All proceeds will be paid directly to Dr. Grant Shandler.

Medi-Cal Patients
Your Medi-Cal coverage will be verified and we will submit claims to your insurance for any covered procedures rendered.

Insurance Patients
We will verify your insurance eligibility and coverage information so that claims may be submitted following treatment. Not all services are covered benefits in all contracts. Your employer has selected the level of coverage based on the premium paid. Please remember we submit claims as a courtesy to our patients, however, the insurance contract is one between subscriber (parent/guardian) and insurance company. You, the parent or legal guardian are ultimately responsible for any balance on the account regardless of insurance involvement.

Your estimated portion is due on the date of service. Estimated portions are based upon historical information for each carrier. For extensive treatment, a pre-treatment estimate can be submitted to your insurance per your request. A pretreatment estimate is not a guarantee of benefit or payment. Actual benefits are not determined until your insurance carrier receives a claim for processing. While we do our best to provide accurate information and to collect the maximum benefit for treatment rendered, there are times when a balance will remain after you have made a personal payment and the insurance has made their payment. There are no contract adjustments or write-offs on any balance after an insurance company has made their payment. If you have not paid your balance within 90 days, a finance charge of 1% will be added to your account each month until paid. We will be glad to send a refund to you once we have received payment from your insurance carrier.

A few companies send the insurance payment to you directly. We will still file the claims on your behalf as a courtesy. For these insurances, full payment for services will be due at the time of service.

Missed Appointment/Late Cancellation Fee
For those who have missed or cancelled within 48 hours, two or more prior appointments within the last year, a deposit of $50 will be required to reschedule.

_____ _____
Patient's Name (print) Patient's Date of Birth

_____ _____ _____
Parent or Legal Guardian (print) Signature Date

Acknowledgement of Receipt
of:
Dental Materials Fact Sheet & Notice of Privacy Practices

By Signing this document, I acknowledge that I have received a copy of

☐ Dental Materials Fact Sheet

☐ Notice of Privacy Practices

_____ _____

Patient's Name (print) Patient's Date of Birth

_____ _____ _____

Parent or Legal Guardian (print) Signature Date

CONSENT FORM

PHOTOGRAPH RELEASE

Here at Seahorse Kids Dental, we make every effort possible to make our patients feel special. We love to share pictures of our patient's beautiful smiles on our Website, Facebook Page, Instagram and other office related materials for our friends and family to see how much fun a visit to the dentist can be! Please check one of the following boxes and sign below.

☐ **I AGREE** and hereby grant full permission to Seahorse Kids Dental, its doctors and staff to use either myself or my child/children's name(s), photographs, and testimonials for marketing purposes for the practice and in any advertising materials. This consent serves to waive all rights of privacy or compensation which I may have in connection with the use of my and/or my child's photograph or name.

☐ **I DO NOT AGREE** to have my or my child's name or photograph used for public viewing.

_____ _____

Patient's Name (print) Patient's Date of Birth

_____ _____ _____

Parent or Legal Guardian (print) Signature Date