KYDENTISTRY4KIDS.COM
WELCOME TO OUR OFFICE

Child's Information (Patient)

Name _____ Nickname _____

Address _____ Birthdate _____ Sex _____

City/State/Zip _____ School _____

Chief Complaint _____

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

Guardian #1

Name _____

Relationship to patient _____

Address _____

City/State/Zip _____

Home Phone (_____)_____

Cell Phone (_____)_____

Employer _____

Business Phone if OK to call (_____)_____

Social Security # _____

Date of Birth _____

Email _____

Guardian #2

Name _____

Relationship to patient _____

Address _____

City/State/Zip _____

Home Phone (_____)_____

Cell Phone (_____)_____

Employer _____

Business Phone if OK to call (_____)_____

Social Security # _____

Date of Birth _____

Email _____

Person responsible for the account: _____

Any other Guardian: _____

Emergency Information: If we are unable to contact the parent, whom should we contact?
(DO NOT LIST YOURSELF OR SPOUSE)

Name _____ Relationship _____ Phone _____

INSURANCE INFORMATION

Primary Dental Insurance

Cardholder Name _____

Employer _____

Ins. ID # _____

Date of Birth _____

Insurance Co. _____

Secondary Dental Insurance

Cardholder Name _____

Employer _____

Ins. ID # _____

Date of Birth _____

Insurance Co. _____

AUTHORIZATION AND RELEASE

I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such dental care to third party payors and/or other health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or that of anyone for whom I have aurthorized treatment.

X _____

**** SIGNATURE OF PATIENT OR GUARDIAN IF MINOR** **DATE**

Appointment Policy

At Kentucky Dentistry for Kids we strive to stay on schedule and respect your time as a busy parent. We cannot stay on schedule without that same respect and cooperation from you.

Please review the details of our Appointment Policy:

- We reserve the right to reschedule your child's appointment if you arrive more than 15 minutes past your appointment time. Many of our appointments are only scheduled for 30 minutes and missing half of that allotted time does not give us time to provide quality care to your child.

- You will receive notification of your missed appointment by mail with a reminder for you to call us to reschedule at a more convenient time for you.

- After 3 missed appointments, you will receive notification by mail that your child has been dismissed from the practice. This total includes all siblings in the family.

- Sedation appointment times are very limited. Because of this, after 2 missed sedation appointments, you will be notified that your child has been dismissed from the practice.

If you need to cancel your appointment, we ask that you give us 24-hour notice. Also, if you are running late for your appointment, please call us to let us know. Our staff will do what we can to accommodate your scheduling needs. We understand that illness and other circumstances can happen, but we just ask that you keep us informed so that we can provide the best care possible to all of our patients.

Thank you for your cooperation.

Signature: _____ Date: _____