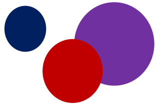
JUST KIDZ DENTISTRY PC

Health History Form



We are delighted to have you as a new patient. May we extend our sincere thanks for the opportunity to meet your child's dental needs. We look forward to a continued relationship with you!

WELCOME TO OUR PRACTICE!

1 Tell Us About Your Child

Child's Name ____________________________________

Nickname ____________________________________

★ Male ★ Female

Birthdate ____________________ Age ______________

Mobile/Home # ____________________________________

SS# ____________________________________

Home Address ____________________________________

____

____

2 Mother's Information

Name ____________________________________

★ Mother ★ Stepmother ★ Guardian

Birthdate ____________________________________

Employer ____________________________________

M# ____________ H# ____________ Othr# __________

SS# ____________________________________

3 Father's Information

Name ____________________________________

★ Father ★ Stepfather ★ Guardian

Birthdate ____________________________________

Employer ____________________________________

M# ____________ H# ____________ Othr# __________

SS# ____________________________________

4 Who is Accompanying the Child

Name ____________________________________

Relationship ____________________________________

Do you have legal custody of this child?

★ Yes ★ No

5 Person Responsible for Account

Name ____________________________________

Relationship ____________________________________

Billing Address ____________________________________

____

M# __________ H# ____________ Othr# ___________

E-mail ____________________________________

6 Primary Dental Insurance

Ins. Co. Name ____________________________________

Address ____________________________________

____

Ins. Co. Phone# ____________________________________

Group # ____________________________________

Policy Owner's Name ____________________________________

SS# or ID# ____________________________________

Policy Owner's Employer ____________________________________

____

7 Secondary Dental Insurance

Ins. Co. Name ____________________________________

Address ____________________________________

____

Ins. Co. Phone# ____________________________________

Group # ____________________________________

Policy Owner's Name ____________________________________

SS# or ID# ____________________________________

Policy Owner's Employer ____________________________________

____

Our office is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA.

8 Dental History

Is this your child's first visit to the dentist? ___________

If not, how long since the last dental exam? ___________

Were x-rays taken at previous dental visit? ___________

Have there been any injuries to the teeth,
face or mouth? ★ Yes ★ No

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 Lip Sucking/Biting Y N Nail Biting
Y N Nursing bottle habits Y N Finger habit

Has the child ever had a serious or difficult problem associated with previous dental work? ★ Yes ★ No

If yes, please explain ______________________

____

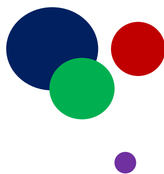
Is the child's water fluoridated? ★ Yes ★ No

Is the child taking any fluoride supplements? ★ Yes ★ No

Has the child ever had any pain or tenderness in his/her jaw? ______________________

Does the child brush his/her teeth daily? ★ Yes ★ No

Floss his/her teeth daily? ★ Yes ★ No



9 Health History

Has the child ever had any of the following problems?

Y N Abnormal Bleeding
Y N Allergies to any Drugs
Y N Any Hospital Stays
Y N Any Operations
Y N Asthma
Y N Cancer
Y N Congenital Heart Disease
Y N Convulsions/Epilepsy
Y N Rheumatic/Scarlet Fever
Y N Frequent ear infections
Y N Handicaps/Disabilities
Y N Hearing Impairment
Y N Heart Murmur
Y N Hemophilia
Y N Hepatitis
Y N HIV/AIDS
Y N Kidney/Liver Problems
Y N ADD/ADHD
Y N Allergies to Latex
Y N Autism

Please discuss any serious medical problems the child has had______________________

____

____

Please list all the drugs the child is taking

____

Please list drugs the child is allergic to

____

Is the child currently under the care of a physician?

____

Child's Physician ______________________

Phone #______________________

Please describe the child's current physical health
★ Good ★ Fair ★ Poor

10

Tell us how you heard about Just Kidz Dentistry: ______________________

____

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 my child may need.

Printed Name of Parent or Guardian: ______________________

Signature of Parent or Guardian: ______________________

Date: ______________________

Relationship to Patient: ______________________

Email & Text Appointment Reminders!- We invite you to participate in our online system.

Email: ______________________ Email Opt OUT ☐ Parent/Guardian Initial _______

Mobile:______________________ Text Opt OUT ☐ Parent/Guardian Initial _______

"We're in this together!"

Just Kidz Dentistry

1320 W. Northmoor Rd. Ste. A
Peoria, IL 61614
309-690-3368

124 Eastgate Dr. #3
Washington, IL 61571
309-694-3368

Date________________________

Patient(s):____

I hereby instruct and direct _______________________________ Insurance Company to pay by check made out and mailed to:

Just Kidz Dentistry

1320 W. Northmoor Rd. Ste. A
Peoria, IL 61614

124 Eastgate Dr. #3
Washington, IL 61571

Or

If my current policy prohibits direct payment to doctor, I hereby also instruct and direct you to make out the check to me and mail it as follows:

Just Kidz Dentistry

1320 W. Northmoor Rd. Ste. A
Peoria, IL 61614

124 Eastgate Dr. #3
Washington, IL 61571

For the professional or dental expense benefits allowable, and otherwise payable to me under my current insurance policy as payment toward the total charges for the professional services rendered. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner, any balance of said professional service charges over and above this insurance payment.

A photocopy of this Assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney involved in this case.

I authorize doctor to initiate a complaint to the Insurance Commissioner for any reason on my behalf.

Dated at Just Kidz Dentistry this ___________ day of __________________, 20________.

____
Signature of Policyholder

____
Witness

Signature of Claimant, if other than Policyholder:____

FINANCIAL POLICY
JUST KIDZ DENTISTRY

Thank you for choosing us as your child's dental provider. We are committed to your successful treatment. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy. We require you to read and sign this policy prior to any treatment.

All patients must have a completed Health History Form before seeing the dentist.

PAYMENT FOR YOUR VISIT IS DUE AT THE TIME OF SERVICE. ANY DEDUCTIBLE AND/OR CO-PAY IS ALSO DUE AT THE TIME OF SERVICE. WE RESERVE THE RIGHT TO RESCHEDULE ANY APPOINTMENT FOR WHICH PAYMENT HAS NOT BEEN MADE.

WE ACCEPT CASH, CHECKS, MASTERCARD, VISA, DISCOVER OR CARE CREDIT.

WE OFFER AN EXTENDED PAYMENT PLAN WITH PRIOR APPROVAL.

Regarding Insurance:
If you have dental insurance, Just Kidz Dentistry will phone your Insurance carrier to verify your benefits before your first visit. You will be informed of your payment responsibilities verbally at your first visit.

At your first visit we will need to make a copy, (front and back) of your current Insurance card. You will also need to sign an "Assignment of Benefit" form, which allows your Insurance carrier to send payment directly to Just Kidz Dentistry. As a courtesy, Just Kidz Dentistry will bill your Insurance carrier for each visit. However, we do require that your deductible and/or co-pay be paid at the time of service or we reserve the right to reschedule your appointment. If your Insurance Company has not paid your account in full with 45 days, the balance will become your personal responsibility. We will require that you pay us the balance in full and you must check with your Insurance Company to find out why payment was not made. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract.

Usual & Customary Rates:
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any Insurance Company's arbitrary determination of usual and customary rates.

Minor Patients:
The adult accompanying a minor (the parent or guardian of a minor) is responsible for payment. If there is a court order indicating the parent not present is responsible for dental bills, Just Kidz Dentistry will still expect deductibles and/or co-pays be paid on the date of service. The court order is between both parents of the minor, not Just Kidz Dentistry and the parent. Therefore, if full payment is not received within 45 days, the parent accompanying the child to the appointment is responsible for full payment. Reimbursement from others is not the responsibility of Just Kidz Dentistry.

Billing:
Statements will be mailed to all accounts showing the balance owed. If your insurance company has not paid the balance in full within 45 days, the outstanding charges become your responsibility. We will expect you to pay us the balance in full and retrieve reimbursement from your insurance company. Interest charges of 1 ½% will be assessed to accounts with a balance over 30 days.

Patient balances over 120 days, will be sent to an outside collection agency for collection proceedings. There will be a collection cost fee of 30% of the balance owing added onto any account sent to the outside collection agency.

Late Cancellation/No Show Policy:
Office hours are Monday - Thursday 8:00 a.m. to 5:00 p.m.
If an appointment needs to be rescheduled and/or cancelled, please call 690-3368(Peoria) or 694-3368(Washington) 24 hours before the appointment to avoid a late cancellation or no show charge.

____ _______________
Signature of Responsible Party Date

____ _______________
Signature of Co-Responsible Party Date

Welcome!! We want to know YOU better!

Do you have a nickname?

What is your favorite toy?

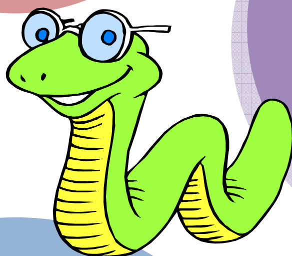
What's your favorite color?

Do you play sports?

Are you ticklish?

Do you like to read, what is your favorite book?

Do you have a pet?



What grade are you in and what's your favorite class?

What is your favorite season?

Have you ever been to the dentist?

What is your favorite thing to do with your family?

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