leap kids dental

Affiliate of RockDental BRANDS

Patient Information

Chart #_____ Initials _____

Updated _____

Child's Information

Today's Date _____

Patient's Name _____

Nickname _____

Child's SSN _____

☐ Male ☐ Female

Child's DOB _____ Age _____

Child's Address _____

City, State, Zip _____

Child's Home # _____

School _____ Interests & Hobbies _____

Mother's Information

☐ Biological mother ☐ Step mother ☐ Guardian

Name _____

DOB _____

Hm# _____ Wk# _____ Ext_____

Cell# _____

Employer _____

Email _____

SSN _____

Father's Information

☐ Biological father ☐ Step father ☐ Guardian

Name _____

DOB _____

Hm# _____ Wk# _____ Ext_____

Cell# _____

Employer _____

Email _____

SSN _____

Parent's marital status:

☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed

Consent For Treatment

I request and consent to the performance of comprehensive dental treatment by the treating dentist and staff. I further authorize any necessary radiographs (x-rays) and photographs needed for the diagnosis and treatment of my child's dental condition.

Comprehensive dental treatment and procedures include examination, teeth cleaning, fluoride application, restorations (fillings), crowns, endodontic treatment (tooth nerve treatment), extractions, and space maintainers.

I acknowledge that dental treatment for children includes efforts to guide their behavior by helping them understand the treatment in terms appropriate for their age and providing an environment likely to help children learn to cooperate during treatment.

_____ _____

Signature of Parent or Guardian **Date**

Where did you hear about us?

☐ Magazine ☐ Radio ☐ Billboard ☐ Online

☐ Newspaper ☐ TV ☐ Local event

☐ Referral- If so, who? _____

Who is filling out this information?

Name _____

Relation _____

Do you have legal custody of this child? ☐ Yes ☐ No

If not, please provide legal paperwork

Dental Insurance Information

Does your child have dental insurance? ☐ Yes ☐ No

Please give all insurance cards to receptionist

Insurance Co. name _____

Insurance Co. Address _____

Insurance Co. Phone # _____

Group # _____

Member ID _____

Policy Holder Name/Relationship to Patient

_____

DOB _____ SSN _____

Employer _____

If Patient does not have dental insurance, how do you intend to pay?

☐ Cash ☐ Check ☐ Visa ☐ MasterCard ☐ Care Credit

I certify that the above questions have been answered to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. It is also my responsibility to inform this office of any changes in my child's medical status. 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 payers and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also authorize the dental staff to perform the necessary dental services my child may need.

_____ _____

Signature of Parent or Guardian **Date**

leap kids dental

Affiliate of RockDental BRANDS

Health Information

Chart #_____ Initials _____

Updated _____

New Patients ONLY

Reason child is here today _____

Is this your child's first dental visit? ☐ Yes ☐ No

Date of last visit _____

Has your child had an unfavorable experience at a dental office?

☐ Yes ☐ No If yes, please explain_____

Child's previous dentist _____

Does your child grind his/her teeth? ☐ Yes ☐ No

Is your child a thumb sucker? ☐ Yes ☐ No

If your child was bottle-fed, at what age was it discontinued _____

Does your child snore or have sleep apnea? ☐ Yes ☐ No

Is your child a "mouth breather?" ☐ Yes ☐ No

Medical Information

Physician's Name_____

Is your child:

Under the care of a doctor at present time?

☐ No ☐ Yes – when/why?_____

Up to date with immunizations?

☐ No ☐ Yes

Currently taking any medication (prescription or over the counter)?

☐ No ☐ Yes – what?_____

Has your child:

Experienced unfavorable reactions to any medication?

☐ No ☐ Yes – what?_____

Ever been hospitalized or had surgery?

☐ No ☐ Yes – for?_____

Ever had a serious head or neck injury?

☐ No ☐ Yes – what?_____

Ever complained of TMJ discomfort?

☐ No ☐ Yes

Allergies

Is your child allergic to any of the following?

☐ Aspirin ☐ Penicillin ☐ Codeine ☐ Acrylic ☐ Metal ☐ Latex

☐ Local Anesthetics ☐ Sulfa Drugs

☐ Other (including food/material/dye) _____

_____

On a special diet?

☐ No ☐ Yes – type?_____

Medical History

Has patient ever been diagnosed with any of the following?

- ☐ ADD/ADHD
- ☐ Anaphylaxis
- ☐ Anemia
- ☐ Arthritis/Gout
- ☐ Artificial Heart Valve
- ☐ Artificial Joint
- ☐ Asthma
- ☐ Autism
- ☐ Behavior Problems
- ☐ Blood Disease
- ☐ Blood Transfusion
- ☐ Brain Injury
- ☐ Breathing Problems
- ☐ Bruise Easily
- ☐ Cancer
- ☐ Cerebral Palsy
- ☐ Chemotherapy/ Radiation Therapy
- ☐ Chest Pain
- ☐ Cleft Lip/Palate
- ☐ Cold Sore/Fever Blister
- ☐ Congenital Heart Disorder
- ☐ Convulsions
- ☐ Cortisone Medication
- ☐ Diabetes
- ☐ Down's Syndrome
- ☐ Drug Addiction
- ☐ Eating Disorder
- ☐ Emphysema
- ☐ Epilepsy/Seizures
- ☐ Excessive Bleeding
- ☐ Excessive Thirst
- ☐ Fainting/Dizziness
- ☐ Frequent Cough
- ☐ Frequent Headaches
- ☐ Heart Murmur
- ☐ Heart Trouble/ Disease
- ☐ Hepatitis A, B or C
- ☐ High Blood Pressure
- ☐ HIV+/AIDS
- ☐ Hives/Rash
- ☐ Hypoglycemia
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Irregular Heart Beat
- ☐ Kidney Problem
- ☐ Leukemia
- ☐ Liver Disease
- ☐ Low Blood Pressure
- ☐ Lung Disease
- ☐ Mental Disorder
- ☐ Nutritional Deficiencies
- ☐ Osteoporosis
- ☐ Pace Maker
- ☐ Pain in Jaw Joints
- ☐ Parathyroid Disease
- ☐ Psychiatric Care
- ☐ Recent Weight Loss
- ☐ Renal Dialysis
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Sickle Cell Disease
- ☐ Sinus Trouble
- ☐ Sleep Apnea
- ☐ Spina Bifida
- ☐ Stomach/ Intestinal Disease
- ☐ Stroke
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Tumors/Growths
- ☐ Ulcers
- ☐ Any other condition or serious illness not listed above?

_____

_____

_____

_____

_____

I certify to the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status.

_____ _____

Parent/Guardian Signature **Date**

_____

Doctor Signature

leap kids dental

Affiliate of RockDental BRANDS

Acknowledgement Of Receipt Of Notice Of Privacy Practices And Consent

I have received and/or reviewed a copy of Leap Kids Dental Notice of Privacy Practices.
You may refuse to sign this acknowledgement. Please note that refusal to sign would affect our ability to submit insurance claims on your behalf. This action would require payment in full at the time of service.

_____	_____	_____
Parent/Guardian ONLY signature	**Child's name (or Children)**	**Date**

Accompanying Child Consent

I authorize the following individuals to act as appointed health care representatives with whom my child's information may be discussed. I also authorize and give consent for the following individuals to bring my child to dental appointments and make treatment decisions on my behalf. ***(List names AND relationship of anyone else that can bring your child to dental appointments and make dental treatment decisions on the lines below.)***

☐ Check here if no other individual can bring your child to dental appointments.

Full Name of Individual	Relationship
_____	_____
_____	_____

_____	_____	_____
Parent/Guardian ONLY signature	**Child's name (or Children)**	**Date**

Model Photo and Video Release

I hereby grant Leap Kids Dental Team the absolute and irrevocable right and unrestricted permission to use photos/videos taken of me or in which I may be included with others, and to use, re-use, publish and re-publish the same in whole or in part, individually or in conjunction with other photos/videos and in conjunction with any media now or hereafter known, and for any purpose whatsoever for illustrations, promotion, art, editorial, advertising and trade, or any other purpose whatsoever without restriction.

_____	_____	_____
Parent/Guardian ONLY signature	**Child's name (or Children)**	**Date**

Collection Policy

You agree, in order for us to service your account or to collect any amounts you may owe us, we may call you at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also communicate with you by sending text messages or e-mails to your wireless number or e-mail address. Methods of contact may include using a pre-recorded/artificial voice and/or the use of an automated dialing device. These authorizations shall remain in effect until individually withdrawn by you in writing to our facility and/or any others to which authorization has been extended. I have read this disclosure and agree that Leap Kids Dental or affiliated collection agency may contact me as described above.

_____	_____	_____
Parent/Guardian ONLY signature	**Child's name (or Children)**	**Date**

leap kids dental

Affiliate of RockDental BRANDS

We are glad you have made an appointment for your child for important oral health care. Regular dental visits every 6 months, including examinations, cleanings, fluoride treatments, dental sealants, and fillings are important to keep teeth healthy. It is especially important that you keep your appointment! Valuable time has been reserved for your child's care. A missed appointment results in lost time which could be used for another patient waiting to receive treatment. Every effort is made to keep on schedule so we respectfully ask patients to be prompt and keep their appointments. The office attempts to schedule appointments at your convenience and when time is available.

Please take a moment to familiarize yourself with our appointment policy. Thank you!

Broken/Missed Appointments

Your child's scheduled appointment is reserved specifically for them. We try to remind patients by telephone prior to the appointment, but **please do not depend on this courtesy**. If a cancellation is unavoidable, please call the office at least 48 hours in advance so that we may give your child's appointment time to another patient. If you do not cancel your child's appointment with more than 48 hours notice or if you do not bring your child to the appointment, we will consider this to be a broken/missed appointment. **If 2 broken appointments occur, our office reserves the right not to schedule any subsequent appointments for your child.** If multiple children were scheduled on the same day and an appointment was broken, we reserve the right to schedule only one child per day.

Occasionally, children's illnesses or other unexpected emergencies make it necessary to cancel an appointment with less than 48 hours of notice. Please contact our office immediately and we will do our best to accommodate your situation.

Late Arrivals

If you arrive more than 10 minutes late for your child's appointment, you may be asked to reschedule for the next available appointment time. Again, please call at least 48 hours in advance if a cancellation is unavoidable.

Appointment Delays

We strive to see all patients on time for their scheduled appointment. We make every effort to stay on schedule. Additionally, there are times when our schedule is delayed in order to accommodate an injured child or an emergency. Please accept our apology in advance should this occur during your child's appointment. We will provide you the same courtesy if your child is in need of emergency treatment. We ask that if your child is not called back in a timely fashion, to please notify a staff member.

A parent or legal guardian (with official documentation) must be present in the office during the initial examination and/or any restorative appointments.

For the safety and privacy of all patients, other children who are not being treated should remain in the reception room with a supervising adult.

I have read and understand Leap Kids Dental appointment policy.

_____	_____	_____
Parent/Guardian signature	**Child's name (or Children)**	**Date**

leap kids dental

Affiliate of RockDental BRANDS

Text and Email Policy

Leap Kids Dental can email and/or text you appointment reminders and general information about our services. If you would like to receive communications via email or text in the future, please read and sign the consent attached below.

Consent to Email and/or Text Message for Appointment Reminders and Other Communications:

You may be contacted via email and/or text messaging to remind you of an appointment, to obtain feedback on your experience with our team, and to provide general treatment reminders and information about our products and services. By signing below, you consent to receiving appointment reminders and other communications/information via email or text from our practice sent to any email address or phone number you provide to us. Any email or text messages we send may not be encrypted or otherwise protected and could be intercepted by a third party. By executing this consent, you assume the risk that information contained in any such communication will be intercepted. We will not charge you for sending texts or emails, but chargers from your carrier may apply. I understand that this request to receive emails and/or text messages will apply to all future appointment reminders and communications sent by our practice until I request a change in writing.

Patient Name _____ Guardian Name (if patient is a minor) _____

Communication Preference (Please Circle One) **Email** **Text**

Signature _____ Date_____

Non-Discrimination Policy

DISCRIMINATION IS AGAINST THE LAW

Leap Kids Dental complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Leap Kids Dental does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Leap Kids Dental:

Provides free aids and services to people with disabilities to communicate effectively with us, such as:

-Qualified sign language interpreters

-Written information in other formats (large print, audio, accessible electronic formats, other formats)

Provides free language services to people whose primary language is not English, such as:

-Qualified interpreters

-Information written in other languages

If you need these services, contact **Paul D. McNiel, Chief Compliance Officer**.

If you believe that Leap Kids Dental has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: **Paul D. McNiel, Chief Compliance Officer** 610 Clinton Ave. Little Rock, AR, 72201. 501-259-8331. paul.mcniel@rockdentalbrands.com. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, **Paul D. McNiel, Chief Compliance Officer** is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
Room 509F, HHH Building
Washington, D.C. 20201
1-800-368-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

leap kids dental

Affiliate of RockDental BRANDS

Non-Discrimination Policy, Continued

Translation services are available in the following languages:

አማርኛ
ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-844-313-7625.

العربية
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-313-7625 رقم

中文
注意：如果 使用繁體中文，可以免費獲得語言援助服務。請致電 1-844-313-7625

Oroomiffa
XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-844-313-7625.

فارسی
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما 1-844-313-7625 تماس بگیرید.

Français
ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-844-313-7625.

Deutsche
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-844-313-7625.

ગુજરાતી
સુચના: જો તમે ગુજરાતી બોલતા હો, તો નઃશુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો 1-844-313-7625.

हिंदी
ध्यान दे: यदि आप हिंदी बोलते है तो आपके लिए मुफ्त मे भाषा सहायता सेवाएं उपलब्ध है। 1-844-313-7625.

Hmong
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-313-7625.

日本語
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-313-7625。

한국어
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-313-7625.

ลาว
ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ 1-844-313-7625

Marshallese
LALE: Ñe kwōj kōnono Kajin Majōļ, kwomaroñ bōk jerbal in jipañ ilo kajin ņe aṃ ejjeļọk wōṇāān. Kaalọk 1-844-313-7625.

Pennsylvania Dutch
Wann du [Deitsch (Pennsylvania German / Dutch)] schwetzscht, kannscht du mitaus Koschte ebber gricke, ass dihr helft mit die englisch Schprooch. Ruf selli Nummer uff: Call 1-844-313-7625.

português
ATENÇÃO: Se fala português, encontramse disponíveis serviços linguísticos, grátis. Ligue para 1-844-313-7625.

русский
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-313-7625.

Srpsko-hrvatski
OBAVJEŠTENJE: Ako govorite srpskohrvatski, usluge jezičke pomoći dostupne su vam besplatno. Nazovite 1-844-313-7625.

Español
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-313-7625.

pilipino
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-313-7625.

Tiếng Việt
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-313-7625.

By signing below, I agree that I have read and understand Leap Kids Dental's Non-Discrimination Policy.

Signature of Patient/Parent/Guardian _____ Date _____

leap kids dental

Affiliate of RockDental BRANDS

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I acknowledge that I have received your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time to obtain a copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that Leap Kids Dental may restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand Leap Kids Dental is not required to agree to my requested restrictions, but if Leap Kids Dental does agree, then Leap Kids Dental is bound to abide by such restrictions.

Patient Name _____

Relationship to Patient _____

Signature _____ Date _____

List below any person who can receive HIPAA information on this patient.

Name _____ Relationship _____ ☐ Treatment info ☐ Ledger

Name _____ Relationship _____ ☐ Treatment info ☐ Ledger

Name _____ Relationship _____ ☐ Treatment info ☐ Ledger

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason: