Amy E Schmitt-Kingston DDS

We are pleased to welcome you and your child to our practice. We look forward to working with you in maintaining your child's dental health.

YOUR CHILD

Today's Date:			
Child's Name:		Nickname:	
SSN:	Phone:		
Birthdate:	Age:	Sex:	Grade:
School:			
Child's Home Address:			
City:	State:	Zip:	

RESPONSIBLE PARTY

Name:		Birth date:	
Relationship:	SSN:		
Address:			
City:	State:	Zip:	
Home phone:	Cell phone:		
Work phone:	Email:		
Who is responsible for making appointments?			

PARENT OR GUARDIAN INFORMATION

Information for (Select only one): Mother Stepmother Guardian

Marital Status: Single Married Divorced Widowed Separated

Name:		Birth date:
Home Phone:	Cell phone:	
Work Phone:	Email:	
Employer:		
Occupation	SSN:	

PARENT OR GUARDIAN INFORMATION

Information for (Select only one): Father Stepfather Guardian

Marital Status: Single Married Divorced Widowed Separated

Name:		Birth date:
Home Phone:	Cell phone:	
Work Phone:	Email:	
Employer:		
Occupation	SSN:	

PRIMARY INSURANCE

Insured's Name:		Birth date:
Relationship:		SSN:
Employer:		
Occupation:		Date Employed:
Insurance Company Address:		
City:	State:	Zip:
Group#:		Employee ID #

ADDITIONAL INSURANCE

Insured's Name:		Birth date:
Relationship:		SSN:
Employer:		
Occupation:		Date Employed:
Insurance Company Address:		
City:	State:	Zip:
Group#:		Employee ID #

DENTAL HISTORY (CONFIDENTIAL)

Previous Dentist:		Phone:
Address:		
City:	State:	Zip:
Date of last dental visit:		
Were x-rays taken? Yes No		How often does your child brush:
How often does your child floss:		Is your child's water fluoridated: Yes No
Does your child take fluoride supplements: Yes No		
Has your child had difficulty with previous dentist visits? Yes No		

Does your child:

Suck Thumb/Finger: Yes No	Suck/Bite Lip: Yes No
Bite/Chew Nails: Yes No	Chew Hard Objects (pencils, etc.): Yes No
Grind Teeth: Yes No	Clench Jaw: Yes No
Any Injuries to Mouth, Teeth, Head: Yes No	

MEDICAL HISTORY (CONFIDENTIAL)

Asthma Yes No	Handicaps/Disabilities: Yes No
Cancer Yes No	Tuberculosis: Yes No
Hepatitis Yes No	Diabetes: Yes No
HIV/AIDS Yes No	Rheumatic Fever: Yes No
Hemophilia Yes No	Congenital Heart Defect: Yes No
Abnormal Bleeding Yes No	Heart Murmur: Yes No
Stomach, Liver, Kidney Problems: Yes No	Convulsions/Epilepsy: Yes No
Anemia Yes No	Fainting Yes No
Sinus Problems Yes No	Thyroid Problems: Yes No

Mononucleosis Yes No	Mumps Yes No
Measles Yes No	Chicken Pox Yes No
Drug/Alcohol Abuse Yes No	
A persistent cough or throat clearing no associated with a known illness (lasting more than 3 weeks) Yes No	
Child's Physician:	Phone:
Address:	
Previous Hospitalizations/Surgeries/Serious Illness	When:
Is your child Currently taking any medications? Yes No If yes Please List:	

Does your child have a history of allergies/sensitivities/adverse reactions to any drugs or medications (Penicillin, Novocaine etc.) or any other substances(latex, environmental, etc.)? Yes No If yes please describe:
Please explain any Medical problems your child has:

AUTHORIZATION FOR CARE & TREATMENT: I hereby agree that Amy E Schmitt- Kingston DDS, may perform care and treatment, and may conduct such examinations and procedures (including x-rays), administer such local anesthetics, analgesia, medication and treatment, as may be directed by my treating practitioner. I acknowledge that no guarantees have been made to me as to the effect of such examinations, tests, procedures or treatment of my condition.

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION: I consent to the use and disclosure of my Protected Health Information by Amy E. Schmitt-Kingston DDS, for the purpose of treatment, payment, and health care operations. Release of medical records and information will be made according to state and federal regulations. I understand that Amy E. Schmitt-Kingston DDS may release medical information to any third party, including my employer, which may be responsible for payment of my hospital and medical expenses. (Release of medical information to employers is limited to those employers who are directly liable for the costs of the patient's health care benefits through an employer self-insured group health plan or worker's compensation, or in other circumstances in which such disclosure is legally allowed).

INSURANCE AUTHORIZATION: I understand that I am responsible for knowing the terms and conditions of my insurance coverage. I further understand that I may be responsible for obtaining prior authorization for certain services in order for my insurance company to pay for those services and I understand that I may be personally responsible for payment if I do not obtain any necessary prior authorization or my insurance benefits are denied, reduced, or terminated.

ASSIGNMENT OF BENEFITS, INSURANCE PROCEEDS AND SETTLEMENTS: If I am entitled to health care services under any insurance policy from any person or organization which may become liable to me to provide such benefits, I assign such benefits to Amy E Schmitt-Kingston DDS and practitioners employed by my practice who render such services to me. I further authorize payment directly to Amy E. Schmitt-Kingston DDS and such practitioners of all such insurance benefits payable to me. Such insurance may include, but is not limited to, private commercial insurance, auto liability insurance, worker's compensation, government sources (if applicable).

I certify that the information given regarding my insurance is accurate and current to the best of my knowledge.

I further assign to Amy E. Schmitt-Kingston DDS any payments for medical benefits payable to me as a result of any settlement or judgment in a lawsuit.

FINANCIAL AGREEMENT: In consideration for services rendered by Amy E. Schmitt-Kingston DDS and practitioners employed by Amy E. Schmitt-Kingston DDS, I guarantee prompt payment of all such services not paid by insurance carriers or third parties within thirty (30) days. I understand that any amount not covered by my insurance carrier or other third party payer is my personal responsibility, and I agree to make payment on such amount. If Amy E. Schmitt-Kingston DDS does not receive such payment within thirty (30) days from the date such balance is due, the bill may be turned over to an attorney or a collection agency and, if so, I agree to pay all reasonable collection cost including attorney's fees and/or collection fees in addition to the payment owed. I give Amy E. Schmitt-Kingston DDS the right to examine my consumer credit report for financial information related to my responsibility to pay for medical services.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE: I acknowledge that I have received or reviewed the Amy E. Schmitt-Kingston DDS, Health Notice on Privacy Practices.

DISCLOSURE TO FAMILY OR FRIENDS INVOLVED IN MY CARE: I understand that I may limit the disclosure of my health information to family members, or other close relatives or close personal friends by notifying a member of the staff assigned to care for me.

I have read all the above statement and accept the terms and conditions as stated.

_____ _____ _____

Patient/Parent/Agent/Guardian Signature Witness Signature Date

Payment is due in full at time of treatment unless prior arrangements have been approved.