17006 San Pedro Ave.
San Antonio, TX 78232
www.captainkidsdental.com

Patient Information

Child's Name____

Last Name First Name Middle Initial

□ Male
□ Female Age_____ Birthday___/____/____ Nickname_________ _ Hobbies_________

Home Address____

Street Apt # City State Zip Code

Mailing Address____

Street Apt # City State Zip Code

Home Phone #____________________ Mom Cell#_______________Dad Cell#____________

How did you hear about us?____

Email Address:____

PARENT' S INFORMATION

Circle One:
Father Stepfather Guardian
Name_________________________________
Date of Birth:____/____/_____
Address (if different from patient)
____
Home Phone________________________
Work Phone________________________
Employer___________________________
SSN#: _____________________________

Do you have dental insurance coverage for a minor/child? YES NO

Circle One:
Mother Stepmother Guardian
Name_________________________________
Date of Birth:_____/_____/_____
Address (if different from patient)
____
Home Phone_________________________
Work Phone__________________________
Employer____________________________
SSN ________________________________

Do you have dental insurance coverage for a minor/child? YES NO

PRIMARY INSURANCE

Subscriber Name:_______________________
Subscriber SSN#:_______________________
Subscriber Date of Birth:___/___/________
Insurance Co.__________________________
Group #_______________________________
Policy/I.D. #__________________________

SECONDARY INSURANCE

Subscriber Name:__________________________
Subscriber SSN#:__________________________
Subscriber Date of Birth:__________/___/_______
Insurance Co. _____________________________
Group #__________________________________
Policy/I.D. #_____________________________

Patient Name: ________________ **Date of Birth:** ________________ **Date:** ________

DENTAL HISTORY

Date of last visit to a dentist ____/____/_____Last Cleaning____/____/_____ Last X-Rays ____/____/______
Reason(s) for seeking dental care:
______First Examination ______Routine Check-Up ______Second Opinion
______Toothache or Swelling ______Accident ______Other:_________________

Do you have any concerns or issues regarding your child's dental health that you would like to be addressed?
____

Has your child had any negative dental experiences? _________________If yes, please explain
____

How do you expect your child to react to the visit today?
______Excellent _______Good _____Fair _______Poor _______Not sure

Is fluoride taken in any form? YES NO
___In vitamins _____In Water ______Drops/Tablets _______Rinse/Gel

Does your child brush teeth daily? YES NO

Does child floss every day? YES NO

Any injuries to mouth, teeth, head? YES NO
If yes, at what age?________Which teeth?________________
What caused the injury?________________________________Treatment received?___________________

Any mouth habits? YES NO
__Thumb/Finger Sucking __Nail biting __Mouth Breathing ___Pacifier ___Sleeping with bottle
Other (please explain)____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?
Name____________________________Relationship_________________Phone#_____________________________
Name____________________________Relationship_________________Phone#_____________________________

PHOTO CONSENT

I _______________________, give consent for Captain Kids Dental to capture a photographic imagery of my child _______________________, for their records. I understand that Captain Kids Dental staff will have access to their photo in the dental record.

Patient/Guardian Signature______________________________ **Date**____

Patient Name:____________________________ Date of Birth:___________________ Date:_____________

CONSENT FOR TREATMENT

The information that I have given is correct and complete to the best of my knowledge. 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 am the legal guardian of the patient.

I authorize the Dentist and Staff to perform the necessary dental procedures: complete dental examination (check-up), prophylaxis (cleaning), fluoride treatment, radiographs (x-rays), sealants, study models, and other diagnostic/preventive aids deemed necessary by the Dentist and the staff to make a thorough diagnosis of my child's dental needs.

I authorize the Dentist and Staff to provide any information to other Doctors (physicians, dentists, etc.) for the purpose of consultation. I understand that prior to providing any treatment, I will be advised about such treatment, that I may ask questions concerning the treatment, and that I may revoke this BEFORE treatment is provided. As the parent/legal guardian of the patient, I do hereby grant the dentist and the staff permission to perform any needed treatment(s).

Patient/Guardian Signature____________________________ Date________________________________

APPOINTMENT AUTHORIZATIONS

For future appointments, if you are planning to send your child with someone other than a parent/legal guardian, please provide the following information (must be 18yrs or older): Name of authorized person(s) to accompany my child for future treatment visits:

1. **NAME:_ ______________________Relationship to Child:________________________________**
2. **NAME:_ ______________________Relationship to Child**:**________________________________**

FINANCIAL AGREEMENT

- **Your insurance is a contract between you, your employer, and the insurance company; our relationship is with you, NOT the insurance company. We file your insurance claim as a courtesy to you.**
- **ALL charges incurred are charged directly to YOU and you are personally responsible for payment. Deductibles and co-payments are due at the time of treatment. We ESTIMATE your co-payments according to your policy. We DO NOT in any way guarantee that your insurance will pay this amount.**
- **If the insurance company doesn't pay within a 60 days, it is required that you pay the balance due.**
- **Your insurance card must be presented at every visit. If there is no insurance card, then payment (cash, check, or credit card) is expected at the time of service.**
- **I hereby authorize payment directly to Captain Kids Dental, the insurance benefits otherwise payable to me, and authorize release of any information required to process insurance claims.**

Patient/Guardian Signature____________________________ Date__________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I, ____________________________________ have reviewed a copy of Captain Kids Dental.
(Parent or Legal Guardian's Name)
Notice of privacy Practices regarding my son/daughter __________________________________.

Patient/Guardian Signature ____ **Date** ________________________
OFFICE USE ONLY: __Patient Refused to Sign __Emergency Situation __Language Barrier __Other