KidShine Pediatric Dental Group

Patient Registration Form

Patient (Your Child's) Registration

Child's Name_____ Preferred / Nickname_____

Gender: Male____ Female____ Home Phone_____

Date of Birth_____

Address_____ City_____State____Zip_____

Patient resides with: Mom Dad Both

Patient's Mother's / Guardian's Information

Name_____ Date of Birth_____

Social Security Number_____ Martial Status_____

Address_____ City_____ State____Zip_____

Home Phone_____ Mobile Phone_____Work Phone_____

E-Mail_____

Patient's Father's / Guardian's Information

Name_____ Date of Birth_____

Social Security Number_____ Martial Status_____

Address_____ City_____ State____Zip_____

Home Phone_____ Mobile Phone_____ Work Phone_____

E-Mail_____

Patient's Primary Dental Insurance Information

Subscriber's Name_____ Name of Insurance Co._____

ID#_____ Military Rank____ Employer_____

Patient's Secondary Dental Insurance Information

Subscriber's Name_____ Name of Insurance Co._____

ID#_____ Military Rank____ Employer_____

Physician's Name_____ Physician's Phone #_____

Whom may we thank for referring you here?_____

(To add additional children please see back page.)

Additional Children Registration

Additional Child

Child's Name_____ Preferred / Nickname_____

Gender: Male____ Female____ Date of Birth_____ Home Phone_____

Patient's Primary Dental Insurance Information (If same as listed on front page please write "same")

Subscriber's Name_____ Name of Insurance Co._____

ID#_____ Military Rank___ Employer_____

Patient's Secondary Dental Insurance Information

Subscriber's Name_____ Name of Insurance Co._____

ID#_____ Military Rank____ Employer_____

Additional Child

Child's Name_____ Preferred / Nickname_____

Gender: Male____ Female____ Date of Birth_____ Home Phone_____

Patient's Primary Dental Insurance Information (If same as listed on front page please write "same")

Subscriber's Name_____ Name of Insurance Co._____

ID#_____ Military Rank____ Employer_____

Patient's Secondary Dental Insurance Information

Subscriber's Name_____ Name of Insurance Co._____

ID#_____ Military Rank____ Employer_____

Additional Child

Child's Name_____ Preferred / Nickname_____

Gender: Male____ Female____ Date of Birth_____ Home Phone_____

Patient's Primary Dental Insurance Information (If same as listed on front page please write "same")

Subscriber's Name_____ Name of Insurance Co._____

ID#_____ Military Rank____ Employer_____

Patient's Secondary Dental Insurance Information

Subscriber's Name_____ Name of Insurance Co._____

ID#_____ Military Rank____ Employer_____

KidShine Pediatric Dental Group

MEDICAL & DENTAL HISTORY

Name_____ Date of Birth_____Today's Date_____

Reason for today's visit:_____

Date of your child's last dental visit:_____What was done?_____

How many times does your child brush a day?_____ Floss?_____

Does or has your child:	**YES**	**NO**		**YES**	**NO**
Suck Thumb/Finger	☐	☐	Take Fluoride Supplements	☐	☐
Clench or Grind Their Teeth	☐	☐	Chew Hard Objects (pencils, etc.)	☐	☐
Play any contact sports	☐	☐	Had any Head/Neck/Jaw Injuries	☐	☐

Although we primarily treat the are in and around your mouth, any health problems and medications that you may be taking can have an effect on the dental care we provide for you. Thank you for answering the following medical health questions.

Is your child in good health? **YES**☐ **NO**☐ Is your child under the care of a physician now? **YES**☐ **NO**☐

Has your child ever been hospitalized since birth?_____ Is so, why? _____

_____

Please list any medications, including non-prescription:_____

_____

Has your child ever has any of the following:

YES	**NO**		**YES**	**NO**	
☐	☐	Tonsil/Adenoid problems	☐	☐	Diabetes Type_____
☐	☐	Heart Disease	☐	☐	Epilepsy/Seizures/Fainting Spells
☐	☐	Congenital Heart Defect. Type _____			How Often_____
☐	☐	History of Heart Problems	☐	☐	Tuberculosis
☐	☐	Anemia	☐	☐	Allergies to Antibiotics.
☐	☐	Asthma/Hay Fever			List Type_____
☐	☐	Cancer Type_____	☐	☐	Allergies to Anesthetic
☐	☐	Kidney Disease	☐	☐	Allergies to Latex
☐	☐	Hepatitis/Jaundice/Liver Disease	☐	☐	Other Allergies _____
☐	☐	Aids or HIV Infection	☐	☐	Special Needs Type_____
☐	☐	Hemophilia Type_____	☐	☐	ADD/Behavior Problems
☐	☐	Abnormal Bleeding	☐	☐	Eating Disorder/Problems Feeding
☐	☐	History of Infective Endocarditic	☐	☐	Psychological/Emotional Problems
☐	☐	Any Organ Transplant	☐	☐	Learning Disability
☐	☐	Any Surgeries	☐	☐	Any Type of Abuse
☐	☐	Cleft Lip and Palate	☐	☐	Pregnant

Does your child have any disease, condition, or problem not listed above that you think we should be aware of?

_____

I certify that I have read, understand and provided the above information to the best of my knowledge. I have answered the question about as accurately as possible. I understand it is my responsibility to inform the dental office of any changes in my child's medical status. I authorize KidShine Pediatric Dental Group to gather clinical information, diagnose and perform treatment necessary for my child's dental health care needs.

Signature of Parent/Guardian_____ Date_____

KidShine Pediatric Dental Group

Pearl City Shopping Center
850 Kamehameha Hwy #215
Pearl City, HI 96782
(808) 638-3313

Kapolei Shopping Center
590 Farrington Hwy #155
Kapolei, HI 96707
(808) 428-8019

Financial Agreement/Cancellation/Missed Appointment Policy

Our goal is to provide quality dental care in a timely manner. See below for our updated financial policies and cancellation/ missed appointment policy, effective 2/4/2021. This policy allows us to better utilize available, appointments for our patients in severe pain needing immediate care.

Financial Agreement:
In our continued commitment to provide the highest quality dental care to you and your family, we are pleased to offer these different forms of payment. We appreciate payment for services at the time they are rendered. Patients who have dental insurance can pay their estimated copayments and deductibles at time of service. Payments may be made with Cash, Check, Visa, Mastercard, Discover, or Amex. There will be a fee of $25 for all returned checks.

Alternative Payment Options:

1. Pay-In-Full Discount: We offer a 5% discount for all services over $300, if paid in full prior to services being rendered.
2. Term Loan: We offer CareCredit, which is a financing option for healthcare expenses. Through CareCredit, we can offer (upon approval) an interest-free term loan for up to 18 months, with no down payment, no annual fee, and no prepayment penalty.

Treatment Plan Estimates:
As a courtesy to our patients, we will provide treatment plan estimates prior to treatment rendered so that you may have an estimate for your patient portion. Please note that treatment plans may change and that it is only an estimate of what your insurance will cover.

Insurance Information:
As a courtesy to our insured patients, we will submit claims to your insurance company on your behalf. In order to help you to receive you maximum benefits allowed, we ask that you provide us with your insurance card and any updated insurance information. Any remaining balance not paid from insurance will be patients responsibility.

Cancellation of an Appointment:
To be respectful of the dental needs of other patients, please be courteous and call the office promptly if you are unable to make your child's/children's appointment. This time will be reallocated to someone who is in urgent need of treatment. If necessary to cancel your scheduled appointment, we require 72 hours in advance.

How to Cancel Your Appointment:
To cancel appointments, please call 808-638-3313 or 808-427-9987 and request to speak to someone in the office your appointment is scheduled in.

No-Show Policy:
A "no-show" is someone who misses an appointment without calling 72 hours in advance to cancel. A failure to show up at the time of a scheduled appointment will be recorded in the patient's chart as a "no-show".
Without notice, we charge $50 missed appointment fee & will only schedule on a same day basis.

If patient accumulates 2 no-shows, patient will be released from our office and we will only scheduled your child on an emergency basis for 90 days and assist with finding your child a new dental home.

By signing this agreement, you are agreeing to the terms and conditions specified above.

_____	_____	_____
Parent Name	Parent Signature	Date

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CONSENT FORM

Prior to using or disclosing your protected health information to carry out treatment, payment of health care operations, KidShine Pediatric Dental Group is required under federal law to obtain your consent. Please review this consent. If you agree with its terms, please sign and date this consent below. By signing this consent, you agree that we may use or disclose your protected health information to carry out treatment, payment or health care operations. You have the right to request restrictions on how your protected health information is used or disclosed to carry out treatment, payment or health care operations. However, we are not required to agree to such restrictions. If we agree to a restriction that you request, such restriction will be binding. You have the right to revoke this consent in writing, except to the extent that we have taken action in reliance on your consent.

I,_____(Patient/Guardian), hereby certify that I have read the provisions set forth in this consent.

Signature of Parent/Guardian:_____ **Date:**_____

Print Name:_____

Acknowledgement of Receipt of Notice of Privacy Practice

I,_____(parent/guardian) for_____(patient) have received a copy of this dental office's Notice of Privacy Practices.

Signature of Parent/Guardian:_____ **Date:**_____

Print Name:_____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ❑ Individual refused to sign
- ❑ Communication barriers prohibited obtaining the acknowledgement.
- ❑ An emergency situation prevented us from obtaining acknowledgement.
- ❑ Other (please specify).

Consent by Proxy for Dental Treatment

Please list any adult(s) (proxy) that may be bringing your child(ren) to their dental visits that will be able to consent for their dental treatment and inform us of their medical history. Be advised that protected patient health information may be shared with the proxy to facilitate informed decision making.

Proxy Name:	**Relationship to the child:**	**Phone #:**

This consent form applies to the following child(ren):

Child Name:	**Date of Birth:**

If there are any limitations to the types of dental services for which this consent by proxy is given, please list below (If none, state "None"):

If there are any limitations for the time frame for which this consent by proxy is given, please list below (If none, state "None"):

Contact Information for Parent(s) and Legal Guardian(s):

Parent Name: _____
Daytime Phone: _____
Evening Phone: _____
Cell Phone: _____

Parent Name: _____
Daytime Phone: _____
Evening Phone: _____
Cell Phone: _____

I consent to have the above listed proxies consent to dental treatment for my child(ren).

Signature: _____
Date: _____

Signature: _____
Date: _____

KIDSHINE PEDIATRIC DENTAL GROUP

Pearl City Shopping Center
850 Kamehameha Hwy #215
Pearl City, HI 96782
(808) 638-3313

Kapolei Shopping Center 590
Farrington Hwy #155
Kapolei, HI 96707
(808) 428-8019

CELL PHONE AND VIDEO TAPING POLICY

The use of phones, cameras and other recording devices are restricted while treatment is being performed in the operatories.
This includes all teeth cleanings and dental treatments.

We welcome you to take pictures of your child once treatment is completed.

Print Name: _____

Parent/Guardian Signature: _____ **Date:** _____