36 Division Street
Derby, CT 06418
Ph: 203-734-KIDZ (5439)
Fx: 203-734-5444
ConnectiKIDZ@gmail.com
www.ConnectiKIDZ.com

WELCOME TO OUR PRACTICE!

Child's Name First_____Middle_____Last_____

Nickname/Prefers To Be Called_____

Birthday_____Age (Years)_____Gender M F

Height Feet_____Inches_____Weight_____

Language_____Race_____

Ethnicity (circle one) Hispanic or Latino Not Hispanic or Latino Prefer not to say

Smoking History (circle one) Never Current Former

How Did You Hear About Us?_____

Name of The Person To Thank For Your Referral?_____

Name of School_____

Parent/Guardian Information

Name of Responsible Person_____

Relationship to Child_____

Date of Birth_____Gender M F

SSN_____Occupation_____

Address Street_____City_____State_____Zip_____

Home Phone_____Cell Phone_____Work Phone_____

E-Mail_____

Dental Insurance Information

Name of Insured Person_____

Name of Dental Insurance (s)_____

Insurance ID #_____Policy/Group #_____

Insurance Phone #_____

Insurance ID #_____Policy/Group #_____

Insurance Phone #_____

Relationship to Child_____

Date of Birth_____Gender M F

SSN_____Occupation/Employer Name_____

Employer Address_____

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DENTAL HISTORY

Is this your child's first visit to a dentist?_____

Date of last dental exam _____

What concerns you most about your child's dental health?_____

How often does your child Brush?_____Floss?_____Take Fluoride?_____

Do you have (Circle One) City Water/Well water

Does your child have a history of? (check all that apply)

___Thumb/Finger Sucking ___Pacifier ___Bottle Use/Sippy Cup

___Breastfeeding ___Dental Trauma ___Bleeding/Sore gums

___Tooth Grinding ___Mouth Breathing ___Speech Problems

Other_____

MEDICAL HISTORY

Name of Pediatrician_____

Phone #____ _____

Please list medications/vitamins/fluoride supplements that your child is currently taking

_____

_____

Does your child have any known allergies? (medications, food, latex, environmental, etc.)_____

_____

Has your child ever been hospitalized or had surgery? Yes/No If Yes, Please Explain_____

_____

Has your child ever been advised by their doctor to take an antibiotic before any dental treatment? If Yes, please explain_____

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Has your child had or currently have any of the following? Please check all that apply:

___ADD/ADHD	___Cancer/Tumors	___Hepatitis	___Respiratory Problems
___AIDS/HIV	___Cerebral Palsy	___High Blood Pressure	___Rheumatic Fever
___Anemia	___Developmental Delay	___Jaundice	___Seasonal Allergies
___Asthma	___Diabetes	___Kidney Disease	___Sinus Problems
___Autistic Spectrum	___Ear/Eye Problems	___Learning Disabilities	___Stomach/GI Problems
___Behavioral Problems	___Epilepsy/Seizures	___Liver Disease	___Thyroid Problems
___Birth Defect	___Genetic Disorder	___Measles	___Tuberculosis
___Bleeding Disorders	___Heart Murmur	___Mononucleosis	___Ulcers
___Blood Transfusion	___Heart Problems	___Mumps	

Other_____

I certify that the above information is correct and up to date to the best of my knowledge. I understand that if there are any changes in the child's health status and/or information that it is my responsibility to inform ConnectiKIDZ as soon as reasonably possible. I understand that the above information will remain confidential.

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

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GENERAL CONSENT

Child's Name _____ **Child's DOB** _____

I give my consent and permission to Julia Bonks, DDS and Staff to treat my child which may include the following dental procedures:

Complete dental exam, cleaning, fluoride treatment, sealants, behavior management techniques, x-rays, study models, photographs, and all/any treatment considered necessary by Dr. Julia Bonks for my child's dental needs. I authorize Dr. Julia Bonks to provide any information to other healthcare providers for the purpose of consultation. I understand that before providing any treatment I will be informed about such treatment by Dr. Julia Bonks or staff member, and that I may ask questions regarding the treatment and that I may withdraw this consent before treatment is provided. I understand that I have the right to have my questions answered during the course of my child's treatment. I have read and understand this consent form. I have been given an opportunity to ask questions about the treatment. The risks and benefits of the proposed treatment have been explained to me. I assign directly to Dr. Julia Bonks all insurance benefits, if any, otherwise payable to me for services provided. I acknowledge that I am financially responsible for all charges that are not covered by insurance. I authorize Dr. Julia Bonks to release any information that is needed including diagnosis, examination records and treatment plan for my child to assure the payment of benefits. I permit the use of this signature for all insurance submissions and claims.

Parent/Guardian Printed Name _____ **Relationship to Child** _____

Parent/Guardian Signature _____ **Date** _____

AUTHORIZATION OF PERSONS TO CONSENT FOR TREATMENT

Dear Parents/Guardians by signing this form, you give permission to the below listed individual(s) to accompany your child and consent to any treatment on your behalf.

Name of authorized individuals(s) to accompany my child for future treatment visits and to be able to consent to the general consent statement above:

1. _____ Relationship to Child _____

2. _____ Relationship to Child _____

3. _____ Relationship to Child _____

4. _____ Relationship to Child _____

Parent/Guardian Printed Name _____ **Relationship to Child** _____

Parent/Guardian Signature _____ **Date** _____

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NITROUS OXIDE AND BEHAVIOR MANAGEMENT CONSENT

It is normal for some children to react to new dental experience with apprehension. We make all efforts to establish the confidence and cooperation of our patients in a dental environment. High quality dental care for all children is our goal, yet occasionally it is difficult, by the lack of cooperation. Some behaviors can be dangerous to the child and staff during dental procedures. For optimal comfort and efficiency we offer several behavior management techniques to facilitate dental treatment. These techniques include:

TELL-SHOW-DO: use of simple explanations and demonstrations, to explain dental procedures.

POSITIVE REINFORCEMENT: using reward mechanisms for a helpful child.

VOICE CONTROL: getting the attention of a child by using different tones of voice.

PROTECTIVE STABILIZATION: technique of holding extremities and/or head of the child to control movement. This includes a rubber mouth prop, holding the child and use of a pedi-wrap/papoose board.

NITROUS OXIDE/("LAUGHING GAS/AIR"): calms apprehensive children, but does not make them fall asleep or numb their teeth. It has few side effects (nausea/vomiting) and lasts only as long as the "air" is being given through a nose mask.

If the above techniques are not effective in managing the child's behavior other options will be discussed such as sedation and/or treatment in a hospital setting.

I have read and understand this information on behavior management. The risks and benefits of the above were discussed with me. I was given the opportunity to ask any questions and was provided answers. I understand that I can revoke my consent at any time prior to treatment.

Child's Name _____

Parent/Guardian Name _____

Signature of Parent/Guardian _____

Relationship to Child _____

Date _____

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Authorization For Use/Disclosure of Patient Photographic and/or Video Images

Patient Photographs/Social Media Release Form

Authorization

I authorize the practice listed above or any of their assignees to take photographs, slides and videos of my child's teeth, jaws and face. I understand that the photographs, slides and videos will be used as a record of my care, and may be used for communication with other health care professionals, educational publications and lectures. The content may also be used for advertising purposes (including website publication, facebook, twitter, instagram, and other social media formats). I do not expect compensation, financial or otherwise, for the use of the above information.

I authorize the use and disclosure of my name, photographic/video images, and/or testimonial for marketing purposes by the practice listed above. I understand that information disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected by HIPAA privacy regulations.

Purpose: The photographic/video images, and/or testimonial may be used for: *Patient care, Social Media and/or Advertising*

Revocability: I understand that I may revoke this authorization at any time, but such revocation must be in writing and received by the practice via registered mail. Revocation affects disclosure moving forward and is not retroactive. This authorization expires 99 years from date signed.

No Treatment Conditions: I understand that the practice cannot condition treatment on whether or not I sign this authorization. If desired a copy of this form can be provided.

Patient Name_____

Parent/Legal Guardian Name_____

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

For Office Use Only

***If copy provided by – Team Member Signature** _____**Date:**_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Decline to Sign This Acknowledgement

I,_____ , understand that a copy of the Notice of Privacy Practices can be given to me if requested.

Child's Name_____

Parent/Guardian Name_____

Relationship to Child_____

Signature_____Date_____

For Office Use Only

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

☐ Individual declined to sign
☐ Communications barriers prohibited obtaining the acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other (Please Specify)

Name/Signature_____Date_____

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Financial Policy

Payment Options

Insurance is welcomed and accepted at our practice. We are in-network with most Dental PPO plans and State Insurance – Husky/Medicaid. We accept all credit cards including Visa, MasterCard, Discover and American Express. We also offer patient financing through CareCredit. Our goal is to deliver the best pediatric dental care for your child and we will be happy to answer any questions that you may have regarding your account.

CareCredit℠
Making care possible…today.

Patients with insurance

Please bring your insurance card along with all necessary forms with you on your first visit. If your insurance should change please provide us with updated information as soon as possible. We will gladly file dental claims for you and contact your insurance company to help you understand your insurance benefits and coverage. For patients with out-of-network insurance, our office can file the insurance claim for your convenience. If you are not sure if we participate with your insurance plan please ask our administrative staff. We will work with you to maximize your insurance reimbursement for covered procedures.

Any balance not paid by your insurance company is solely your responsibility. Insurance typically covers most but not all cost of dental care, and you will be financially responsible for any remaining balance, including any co-payments or plan deductibles.

If your insurance plan has not paid your claim, you will be asked to pay for the dental services provided and establish reimbursement with your insurance company.

Missed/Cancelled Appointments

We ask for your courtesy regarding your child's scheduled appointments. If you are unable to keep the appointment please allow at least 24 hours prior to the appointment time if you must cancel or reschedule. We understand that unforeseen circumstances occur, however, we reserve the right to charge a $25.00 fee for cancellations within 24 hours of appointment or broken appointments.

Hospital Dentistry/Surgical Procedures Deposit

A deposit of $500.00 is required at the time you schedule your procedure, which is refundable within one week of the surgery date. Surgery scheduling is coordinated with a multidisciplinary team including your dentist, doctor, hospital and operating room staff. A deposit allows for your procedure to be secured. A refund equal to the amount deposited will be given if the procedure is cancelled within a week of the scheduled date. If the cancellation is prior to surgery and is due to unforeseen circumstances, the deposit can be applied toward the rescheduled date, otherwise the deposit is non-refundable.

I have read and agree to the above financial policy.

Patient Name_____
Parent/Legal Guardian Name_____
Parent/Legal Guardian Signature _____**Date:**_____