Dentistry for Kids
Dr Kris Hendricks
Dr Kelly Hendricks
Dr James Burneson
Dr Steve Tanner
1439 S St Francis Dr, Santa Fe, NM 87505
505-473-5437

Patient
Name_____Preferred Name_____
Date of Birth:__/__/__ Female___Male___ Current Age_____
Child's Social Security Number_____
Name of Parent/Guardian filling out form_____

Mother's Name_____Marital Status_____
Mother's Social Security Number_____Mother's Birthdate_____
Mother's Employer_____Mother's Work Phone_____
Mother's Mailing Address_____
City_____State_____Zip_____
Home Number: _____ Cell Phone Number:_____
Preferred Contact #(check one): Home___Cell___Email address:_____
Do you allow us to contact you via email or text to communicate patient information? Y___N___

Father's Name_____Marital Status_____
Father's Social Security Number_____Father's Birthdate_____
Father's Employer_____Father's Work Phone_____
Father's Mailing Address_____
City_____State_____Zip_____
Home Number: _____ Cell Phone Number:_____
Preferred Contact #(check one): Home___Cell___Email address:_____
Do you allow us to contact you via email or text to communicate patient information? Y___N___

DENTAL INSURANCE INFORMATION

If you receive financial assistance for your child's dental care, please check the option that applies: Medicaid_____CMS_____Project ANN_____Other_____

Primary Policy Information
Name of Policy Holder: _____
Insurance Name: _____Ins phone #_____
Member ID: _____ Group #_____
Policy Holder's Birthdate _____/_____/_____
Policy Holder's Social Security # _____/ _____/_____(required to file claims)
Employer:_____

Secondary Policy information
Name of Policy Holder: _____
Insurance Name: _____Ins phone #_____
Member ID: _____ Group#_____
Policy Holder's Birthdate _____/_____/_____
Policy Holder's Social Security # _____/ _____/_____ (required to file claims)
Employer:_____

Consent for use and disclosure of health information

Section A: Patient Giving Consent
Patient's Name

Section B: To the parent or guardian--Please read the following carefully
Purpose of consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations. Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, uses and disclosures of your protected health information and of other important matters about your protected health information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your protected health information that we maintain.
You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice at anytime by contacting: Dr. Kris W. Hendricks tel. 505-473-5437 fax. 505-438-3443 2904 Rodeo Park Drive East #300 Santa Fe, NM 87505
Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation and that we may decline to treat you or to continue treating you if you revoke this consent.

Signature:
I, _____ have had full opportunity to read and consider the contents of this consent form and Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature _____ Date _____

If this consent is signed by a personal representative on behalf of the patient, complete the following:
Personal Representative's Name: _____
Relationship to Patient: _____

Dear Responsible Party: The following descriptions of treatment aids may possibly be used by Dr. Hendricks in caring for your child. We will discuss with you their use when applicable.

Nitrous Oxide/Oxygen - This gas mixture is administered through a nose mask; its main purpose is to help reduce anxiety, although it also reduces the perception of pain. Patients do not go to sleep as they are always receiving at least 40% oxygen. Very rare side effects might include nausea, vomiting and dizziness. The effects of the gas end within minutes after stopping its use.

Local Anesthesia - This may be in the form of a topical gel/cream or an injectable liquid. It is used to produce anesthesia of the hard and soft tissues. Allergies are rare, but could include rash, skin eruptions and anaphylactic shock, which could be deadly without prompt medical management. Children must be constantly reminded not to bite or chew on the soft tissue in the anesthetized area.

Rubber dam application - This consists of a clamp that fits over the tooth and a thin piece of rubber that isolates the teeth being treated. It enables us to do a better job of restoring your child's teeth and protects your child from exposure to the materials used in that process.

Fluoride treatment - may be used based on the child's dental history and past exposure to other fluorides.

Extractions - Removal of teeth.

Composite fillings - tooth colored resin fillings.

Stainless steel crowns - used when the tooth is too badly decayed to hold a filling.

Sealants - a thin coating of resin is placed on the biting surfaces of the teeth to prevent decay from starting. The teeth must be cleaned and etched with a mild acid before the sealant is placed. Occasionally some decay is discovered. This requires the placement of a preventative resin restoration, for which a separate fee is charged.

Protective stabilization and gentle restraint - used only when necessary to protect your child and/or the dental team.

Please sign below if you agree to the following statements:
I am informed that in most cases if I fail to keep an appointment without giving the office 24 hours' notice, I will not be granted priority rescheduling.
I am advised that although good treatment results are expected, there can be no guarantee expressed or implied as to the result of treatment or cure.
I understand that, although adverse reactions to routine dental care are rare, they can occur. Adverse reactions may include nausea, vomiting, dizziness, breathing difficulty, allergic reactions, excess bleeding and prolonged numbness. I understand that any of these adverse reactions may require hospitalization and could lead to death.

I authorize Dr. Hendricks and his staff to take the radiographs (x-ray films) necessary to provide good dental care and expect to be informed before any radiographs are taken. If I do not agree to radiographs, a separate form will be provided, releasing the doctors from certain liabilities.

Signed _____ Date _____

WE LOVE ON TIME PATIENTS!!!!

Here at Dentistry for Kids we try our very best to keep our schedule running on time, and you as the patients can help us by arriving a few minutes early to your appointment.

When patients are even slightly late it can throw off our schedule for the whole day.
So—if you are five minutes late we MAY have to reschedule your appointment. We will do our best to see you, but we have to prioritize other patients who are on time that day. If you are ten minutes late or more we will try to find a later opening on the schedule for you that day, or if the schedule is too full we will gladly help you reschedule for another day.

We do our best to see each and every patient, so let us know if something unexpected comes up and we will do what we can to accommodate you.

We totally get that life happens—communicate with us and we'll do our best to take care of you!

I have read and understand the Dentistry for Kids attendance policy:

_____Date:_____

Financial Policy

Your child's dental care is our primary objective. Our professional relationship depends on your clear understanding of our financial policy as well as of your own insurance plan, if applicable.

Payment is due at time of service. If you have dental insurance, as a courtesy to you, we will submit your claims. Since our patients represent over 350 insurance companies, we can't be experts on everybody's policy. It is your responsibility to be familiar with your own policy. If you have questions or confusion, please call your insurance company directly so that there are no surprises.

We have contracts with Dental Source, United Concordia, most Delta Dental plans, and all forms of Medicaid. For other insurance companies we ask you to pay 25% of the day's services as well as gross receipts tax after your appointment. This will be an estimate. We will then bill your insurance and if the insurance company pays out more than expected we will reimburse you. If the insurance company pays less, then we will send you a statement for the remaining balance.

Once we send out a claim, insurance companies are required by law to make a determination on it within 45 days of receiving it. You will then be notified of any balance that is due. We expect payment of that balance within 30 days of notification. Your dental insurance is a contract between you and your insurance company, not this office. We will not become involved in disputes between you and your insurance company, other than to supply factual information as needed.

This office will not become involved in marital or family disputes. The person designated as the responsible party--the one making appointments and bringing the patient to appointments--will be sent all relevant communications, including bills. That individual is responsible for the payments of bills. This person will also receive our phone calls and notices of payment due, regardless of court settlements or personal arrangements.

If someone other than a parent brings a child into an appointment, we need to have a signed parental consent form, authorizing this office to treat the child, before the child can be seen.

We accept as payment: cash, checks, all major credit cards as well as the Care Credit health care credit card. If you have questions about applying for Care Credit, please see our front desk staff.

Other Service Charges:
*18% Annual (1.5% monthly) interest is charged to accounts with outstanding balances 60 days from date of service.
*Returned checks are subject to a $25 service charge.

I have read this policy statement and hereby agree to the conditions herein

(Signed)_____(Date)_____

Dentistry for Kids Kris W. Hendricks, DDS

Patient Name_____ Account #_____

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

Was previous experience __good __bad __other Explain_____

How did you find us? Internet___ Phone Book (which one?)_____ Ad___Friend___Other_____

Please tell us the main reason for today's visit_____

Has your child been experiencing dental pain? __yes __no

Has your child been awake at night from dental pain? __yes __no

Do you have any concerns about your child's dental health?_____

Has your child ever been hospitalized? __yes __no If yes please give date & reasons_____

Is your child allergic to any medications? __yes __no Please identify_____

Is your child currently taking any medications? __yes __no Please identify_____

Reason for the medication_____ Pediatrician name & phone_____

Has your child had: DPT immunization __yes __no Polio vaccine __yes __no Measles Mumps & German measles __yes __no

Is there anything you can tell us about your child that could assist us in taking the best possible care of them?

_____

Does your CHILD now have or have they ever had in the past: (please circle y or n)

Speech problems	Y N	Anemia/Sickle Cell Disease	Y N	Cerebral Palsy	Y N
Hearing problems	Y N	Bruises Easily	Y N	Seizures	Y N
Asthma	Y N	Blood Transfusion	Y N	Kidney/Bladder problems	Y N
Skin problems	Y N	Hepatitis/Jaundice	Y N	Diabetes	Y N
Allergies (other)	Y N	Cystic Fibrosis	Y N	Pregnancy (patient)	Y N

Please Identify Allergies_____

Has patient had heart disease or a heart murmur Y N Please describe_____

Is pre-medication required for dental treatment? Y N Drug preferred_____Child's Weight_____

Please circle all illnesses your child has previously had:

Chickenpox Earaches Measles German Measles Mumps Mononucleosis HIV/AIDS Scarlet Fever Tuberculosis Venereal Disease Tonsillitis

Learning/Behavior Disorders Y N Please describe_____

Has your child had any prior surgeries? Y N Is your child currently scheduled for surgery? Y N Date?_____

Please describe_____

Is there anything else we should know about your child?

Parent/Guardian Signature_____Date_____