KIDSHINE Orthodontics

Date:_____

Patient's Name:_____ _____ _____
Last First M.

Age: _____ Birth Date:_____ _____ _____ Gender: ☐ ☐ ☐
MO DAY YR Male Female Non-Binary

Email Address: _____ Mobile #: _____

Address: _____ _____ _____
Street Number & Name City Zip Code

Employer: _____ Phone#:_____
Company Name/Occupation

Current Dentist:_____ Referred By:_____

PARENT/GUARDIAN INFORMATION (MINORS ONLY):

Father: _____
Name Street Address City Zip

Email Address: _____ Mobile #: _____

Employer: _____ Phone#:_____
Company Name/Occupation

Mother:_____
Name Street Address City Zip

Email Address: _____ Mobile #: _____

Employer: _____ Phone#:_____
Company Name/Occupation

☐ Single ☐ Married ☐ Separated ☐ Divorced

Names & Ages of Other Children in Family: _____

Responsible Party (For Financial Contract): _____
Address: _____ _____ _____
Street Number & Name City/Zip Phone #

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MEDICAL HISTORY

Is the patient in good health? ☐ YES ☐ NO _____
Patient's Physician

Check any of the following for which the patient has been treated:

Diabetes..... ☐
Pneumonia..... ☐
Heart Disease.... ☐
Rheumatic Fever ..... ☐
Bone Disorders..... ☐
Glaucoma..... ☐
Tuberculosis..... ☐

Anemia..... ☐
Epilepsy..... ☐
Asthma..... ☐
Kidney Disease..... ☐
Hepatitis..... ☐
Endocrine Problems.... ☐

Prolonged Bleeding... ☐
Fainting/Dizziness..... ☐
Nervous Disorders..... ☐
Liver Disease ..... ☐
Other..... ☐

List any drugs/medications that are now being taken: _____

_____ ☐ None

List any allergies or drug sensitivity: _____

_____ ☐ None

Have there been any injuries to the face, mouth, or teeth?

Has the patient ever sucked a thumb or fingers? ☐ Yes ☐ No

If yes, until what age? _____

Does the patient have any speech problems? ☐ Yes ☐ No

Reason for consultation: _____

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INSURANCE INFORMATION

Social Security #: (Minors only) _____ _____
Mother SSN Father SSN

Patient SSN: _____

Insurance Carrier: _____ Group #:_____

Subscriber Info: _____ _____ Policy #:_____
Name Birth date

Additional Insurance Carrier: _____Group#:_____

Subscriber Info: _____ _____ Policy #:_____
Name Birth date

Additional Insurance Carrier: _____Group#:_____

Subscriber Info: _____ _____ Policy #:_____
Name Birth date

KIDSHINE Orthodontics

Photo/Video Release Form

The greatest thank you we can get from you is by letting others know about your experience with us. We would like to share your photo/video testimony about your remarkable visit.

I grant KidShine Orthodontics the unlimited right to use photographs and video testimonies for marketing and educational activities connected with Kidshine Orthodontics. I understand that by signing this release that I waive any and all present or future compensation rights for the use of the above stated material.

Patient Name: _____

Parent Signature (Minors only): _____

Patient Signature: _____

Date: _____

Patient Full Name: _____

Financial Policies

At Kidshine Orthodontics, we are committed to providing the best possible orthodontic care to our patients. To ensure the process of paying for treatment is as convenient as possible, we need your assistance and understanding of our payment structure and policies.

- This office only allows (1) responsible party per financial contract.
- As the responsible party, you agree to pay the monthly installment before or by the scheduled due date. No interest will be charged on this contract payment plan. Any additional financial arrangements must be approved in advance.
- In the event of a divorce or separation, the party responsible for the account PRIOR to the divorce or separation remains responsible for the lifetime of the financial contract. After a divorce/separation, the parent authorizing treatment and bringing the child in for appointments will be the one that is responsible for all subsequent charges. If the divorce decree requires the parent to pay all or part of treatment costs, it is the authorizing parents responsibility to collect from the non-custodial or specified parent. ***It is office policy to have (1) contract per patient, we do not offer split contracts.***
- If the account falls 120 days delinquent, no active treatment will occur until the account is brought up to date. You will receive a courtesy letter via certified mail with payment options to bring the account current.
- If the account falls 6 months delinquent, a 2nd courtesy letter will be sent via certified mail with payment options to bring the account current.
- Any accounts 9 months or more delinquent, a dismissal letter will be sent via certified mail. This will terminate our responsibility to the patient.
  The patient has the following options:
    - Arrange alternate financing to pay the entire past due balance and resume active treatment if the patient's teeth and gums are healthy enough to do so.
    - If no arrangements are made, treatment will be prorated and the entire unpaid balance will be sent to a third-party collections agency. From there, the patient can:
        - Remove braces and/or active appliances without retainers
        - Continue orthodontic treatment with another orthodontist. This will require a new financial contract with a new orthodontist.
- We reserve the right to report your account status to any credit reporting agency such as credit bureaus.
- We realize that temporary financial problems may affect timely payment of your account. If such difficulties do arise, we strongly encourage you to contact us promptly for assistance in the management of your account.
- In the event of a transfer to another orthodontist during the course of treatment, your account will be prorated and the account will be settled prior to sending your records to the new orthodontist.

KIDSHINE Dental & Orthodontics

Insurance Policy

If you have orthodontic insurance coverage, Kidshine will submit a claim for services rendered and payments can be made directly to our office. It is **YOUR** responsibility to inform our office of any changes or termination of your coverage. Please remember that we will bill insurance as a courtesy to you as the patient. We estimate what insurance will pay, however it is the insurance company that makes final determination of your eligibility and payments. Any unpaid insurance balance will be the responsible party/patient's responsibility.

Thank you for choosing Kidshine Orthodontics and for the opportunity to provide you and your family with orthodontic services.

Individual Responsible for financial account: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Contact #: _____

Email Address: _____

Patient ID# (for office use only): _____

Signature of Responsible Party: _____ Date: _____