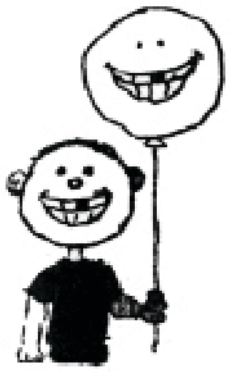


Welcome!

We are pleased to welcome you and your child to our practice. Please take a few minutes to fill out this form as completely as you can. If you have questions we'll be glad to help you. We look forward to working with you in maintaining your child's dental health.

ESPECIALLY FOR KIDS

Angela M. Rogers, D.M.D., M.S.
25811 W. 12 Mile Rd., Suite 202
Southfield, MI 48034
Office: (248) 559-5554
Fax: (248) 559-3114
Making A Difference: One Child At A Time

PATIENT INFORMATION

Date _____ SS/HIG/Patient ID # _____ Birthdate _____

Name of Minor/Child _____ Sex ☐ M ☐ F Age _____
Last Name First Name Middle Initial

Nickname _____ Hobbies _____ Home Phone (____) _____

Home Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

School Name _____ School Phone (____) _____

Person financially responsible _____ Home Phone (____) _____ Work Phone (____) _____

Whom may we thank for referring you? _____

INSURANCE

Father's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone (____) _____ Work Phone (____) _____
(if different from above) (If different from above)

Cell Phone (____) _____ E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Mother's/Guardian's Name _____

Address (if different from patient's) _____

Home Phone (____) _____ Work Phone (____) _____
(if different from above) (If different from above)

Cell Phone (____) _____ E-mail _____

Employer _____

Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for minor/child? ☐ Yes ☐ No

Plan Name _____ Phone (____) _____

Address _____

Group # _____ Policy # _____

Is your child eligible for treatment under Medicaid? ☐ Yes ☐ No Child's Medicaid Recipient I.D. # _____

FOR DENTAL OFFICE USE ONLY

Primary Insurance Co. _____
Name Address Phone Group Number

Deductible ☐ No ☐ Yes Annual Amount _____ Lifetime Amount _____ Benefit Year _____
Class I _____ II _____ III _____ IV _____ Ortho Max _____ Annual Max Benefit _____
Max Used _____ Max Used _____

Secondary Insurance Co. _____
Phone Group Number

Deductible ☐ No ☐ Yes Annual Amount _____ Lifetime Amount _____ Benefit Year _____
Class I _____ II _____ III _____ IV _____ Ortho Max _____ Annual Max Benefit _____
Max Used _____ Max Used _____

Treatment Frequencies

Eligible for x-rays
Yes [ ] No [ ]

Comprehensive Exams _____ F+_____up to age _____ SSCR _____% Age _____ Sealant Coverage Post Composites
Recall Exams _____ B.W. X-rays _____ Acryl. CR _____% Age _____ Yes [ ] No [ ] Yes [ ] No [ ]
Emergency Exams _____ F.M. X-rays _____ Porc. CR _____% Age _____ Age Limit ____%____ Primary____Perm___

MEDICAL HISTORY

Minor/Child's Physician_____ Address_____

Phone (____)_____ City_____State_____Zip_____

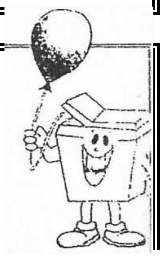
Date of last physical examination_____

	YES	NO	
Is Minor/Child under treatment of physician now?	☐	☐	Medications:_____
Receiving any medications or drugs?	☐	☐	_____
Ever been hospitalized?	☐	☐	_____
Ever had surgery?	☐	☐	Allergies:_____
Is there excessive bleeding when cut?	☐	☐	

Has minor/child had any history of or difficulty with any of the following? If yes. please check **(√)**.

☐	A.1.0.S.IH.1.V	☐	Cerebral Palsy	☐	Hearing Problems	☐	Liver Disease	☐	Speech Problems
☐	Anemia	☐	Chicken Pox	☐	Heart Probloms	☐	Measles	☐	Thyroid Disease
☐	Asthma, Bronchitis or Breathing Problems	☐	Convulsions	☐	Hepatitis	☐	Mental Disabilities	☐	Tuberculosis
☐	Allenhon Deficit (A.D.D.) Hyper Activity	☐	Diabetes	☐	Hypertension (High Blood Pressure)	☐	Mononucleosis	☐	Vision Problems
☐	Bladder Problems	☐	Drug/Alcohol Abuse	☐	Kidney Disease	☐	Mumps	☐	Autism
☐	Brain/Nerve Injury	☐	Epilepsy/Seizures	☐	Learning Disabilities	☐	Rheumatic Fever	☐	Other
☐	Cancer	☐	Fainting	☐	Leukemia/Hemophilia	☐	Sinus Problems	☐	

DENTAL HISTORY



Date of last visit to dentist

Dentist Name Address Telephone

	YES	NO	
Has child complained about dental problems?	☐	☐	If yes, please explain
Any injuries to mouth, teeth, head?	☐	☐	If yes, please explain
Any unhappy experiences?	☐	☐	If yes, please explain

Any mouth habits: tongue sucking, finger sucking, nail biting, mouth breathing, use pacifier, use of sippy cup, sleeping with bottle…….....please circle all that apply.

AUTHORIZATIONS

To the best of my knowledge. the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent

I am the parent, guardian, or personal representative of_____

Please Print Name of Minor/Child

and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to x-rays, and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release

I certify that my dependent(s) is covered by insurance with _____and assign directly to

Name of Insurance Company(ies)

Dr._____all insurance benefits, if any, otherwise payable to me for services rendered.
I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.
The above-named doctor may use my minor/child's health care information and may disclose such information to the above named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

Signature of Parent, Guardian or Personal Representative Date

Please print name of Parent, Guardian or Personal Representative Relationship to Parent

Review with Doctor and/or Staff

INFORMED CONSENT FOR BEHAVIOR MODIFICATION

I am the parent, guardian, or representative of _____

Please Print Name of Minor/Child

Consent the use of sedatives, nitrous oxide, mouth props, restraint, and behavior management modlalities necessary for the safe administration of treatment, which have been thoroughly explained to me by the Doctor and or Staff of Espcdnlly for Kids, P.C.

Signature of Parent, Guardian or Personal Representative Date

Please print name of Parent, Guardian or Personal Representative Relationship to Parent

PLEASE NOTE

The parent/guardian who brings the minor child to his/her first office visit and signs the "parental consent" form wlll be held financially responsible for any charges co-payments for appointments thereafter.

Dr. Angela M. Rogers

Insurance Facts

- No Insurance Carrier pays 100% of All procedures. Dental Insurance is meant to be an aid in receiving Dental care. If we have received all of your insurance information on the day of the appointment, we will be happy to file your insurance claim for you

- We will collect from you the day of service the ESTIMATED amount that the insurance will not pay. We file all insurance claims electronically, so your insurance will receive the claim within days of services being rendered.

- The Percentage paid by insurance is generally determined by how much you or your employer has paid for coverage or the type of contract your employer has set up with the insurance company. Benefits are not determined by our Office.

- We can only assist you in estimating your portion of the cost of treatment. At no time do we guarantee what your insurance will or will not pay on a claim. Deductibles & Co-payments must be considered. We file claims as a courtesy to you.

- MOST IMPORTANTLY, please keep us informed of any insurance changes such as policy name, insurance company address, or a change of employment.

- Unfortunately, insurance companies imply that your dentist is "overcharging" rather than say that they are "underpaying" or that their benefits are low. In general, the less expensive insurance policy will use a lower usual, customary or reasonable(UCR) figure.

ESPECIALLY for KIDS, P.C.
Dr. Angela M. Rogers
Patient Policy & Guidelines

Our Dental Team would like to Welcome you and your family to our office. Our philosophy and goal is to "Make a Difference One Child at A Time". The most effective way for us to do this is with your help by adhering to the following:

- The Practice is Limited to the specialty of Pediatric Dentistry. Your first visit to our office will be an introductory appointment consisting of a Dental Exam, Prophylaxis(cleaning), Fluoride treatment/varnish, and radiographs if necessary to ensure a complete diagnostic treatment plan. We Welcome parents in the operatory at the initial visit. However, through years of experience we have found that when dealing with children for restorative care they behave more independently when parents are not with them. Our purpose is to gain your child's confidence and overcome any apprehension they may have.

- We value your time and will strive to be as timely as possible. Please be mindful that some appointments must occur during school hours. To evaluate and treat your child properly, we do not schedule anyone else in your child's reserved time slot. If you arrive more than 15 minutes late, we will unfortunately have to reschedule you.

- As a courtesy we attempt to remind parents by phone/text or email of the reserved appointment, however, IT IS YOUR RESPONSIBILITY to confirm the appointment. **Failure to confirm a reserved appointment can result in loss of appointment.**

- We require a minimum 24 hour cancellation notice to avoid a Broken/Missed Appointment fee of $60.00 per appointment and $75.00 for sedation appointments. This fee must be paid before you can reschedule another appointment.

- The reimbursement for services when using an insurance plan is between **you and your insurance carrier**, not the Insurance Carrier and the Dentist. Behavior Management fees are charged by all Pediatric Dental Specialists, and range from $60.00-$300.00. Should your child need to be sedated, you will be assessed a fee which may not be covered by your dental insurance. Payment for professional services is due at the time dental treatment is performed. Options for payment are : Cash, Check, Debit/Credit or utilization of Care Credit(ask Business staff for information on Care Credit).

- **The More Informed you are of our office policies and patient guidelines the more effective we can be.**

We consider it a privilege to care for the smiles of your child(ren) while maintain great oral healthcare. It is our pleasure to service you.

_____ Signature Parent/Guardian

_____ Witness EFK Team Member

ESPECIALLY for Kids, P.C.

Especially For Kids, P.C.

Privacy Act Acknowledgment

I have received the Notice of Privacy and I have been provided an opportunity to review it

Child's name _____

Child's birth date _____

Parent signature _____

Date _____

Making a difference one child at a time