KARSON KUPIEC
ORTHODONTICS
AND PEDIATRIC DENTISTRY

CONSENT TO TREAT MINOR

Date _____

As parent(s)/guardian(s) of _____ I/we authorize Karson Kupiec Orthodontics and Pediatric Dentistry to examine and treat my child as necessary. I understand that by signing this form I am accepting all responsibility or full payment of services rendered. If I have insurance coverage I understand that information such as deductible, waiting periods, co-insurace, etc., given to the office by my insurace company is only an estimate and never a guarantee of coverage or payment. I am aware that the office requires 48 business hours notice for any cancellation of scheduled appointment/s and if notice is not given there may be a charge of $50 per appointment canceled. I further understand that all payments are due and payable on the day and services are rendered.

Patient Home Address _____

City/State _____ Zip _____ Phone _____

E-Mail Address _____

Dr. Mr. Mrs. Ms.

Name _____ Relationship _____

Address (if different than above) _____

Phone (if different than above) _____ SS # _____ DOB _____

Employer Name _____ Occupation _____

Work Phone _____ Cell Phone _____

E-Mail Address _____

Signature _____

Whom may we thank for referring you? _____

Friend or Relative not living at same address to contact in the event of an emergency:

Name _____ Phone _____

KARSON KUPIEC
ORTHODONTICS
AND PEDIATRIC DENTISTRY

HEALTH HISTORY

Date _____ Update _____

PERSONAL

Child's Full Name _____ Age _____ Birthdate _____

Nickname (if any) _____ Sex _____ Place of Birth _____

What is your child most interested in? _____

Brothers, names & ages? _____ Sisters _____

Is your child adopted? ☐ Yes ☐ No If yes, does your child know? ☐ Yes ☐ No

Child's pediatrician or physician _____ Telephone _____

Family Dentist _____ Child attends what school? _____

MEDICAL

Has your child had any of the following medical problems? *Check Yes (Y) or No (N).*

Allergies to drugs or food	☐ Yes ☐ No	Ear infections	☐ Yes ☐ No	Hospital stays or operations	☐ Yes ☐ No
Allergies to Laytex	☐ Yes ☐ No	Handicaps or disablities	☐ Yes ☐ No	Learning disabilities	☐ Yes ☐ No
Asthma or lung problems	☐ Yes ☐ No	Heart defect (congenital)	☐ Yes ☐ No	Rheumatic Fever	☐ Yes ☐ No
Blood transfusions	☐ Yes ☐ No	Heart murmur	☐ Yes ☐ No	Trauma to mouth or face	☐ Yes ☐ No
Cancer	☐ Yes ☐ No	Hemophilia or abnormal bleeding	☐ Yes ☐ No	Tuberculosis (TB)	☐ Yes ☐ No
Convulsions or epilepsy	☐ Yes ☐ No	Hepatitis	☐ Yes ☐ No	Cerebral Palsy	☐ Yes ☐ No
Developmental delay	☐ Yes ☐ No	High fevers	☐ Yes ☐ No	Attention Deficit Disorder	☐ Yes ☐ No
Diabetes	☐ Yes ☐ No	HIV+ /AIDS	☐ Yes ☐ No		

Other medical problems: _____

Please discuss problems further, if necessary:

_____

Has your child had any unfavorable reactions to drugs, antibiotics or anesthetics? ☐ Yes ☐ No

Is your child currently taking any medications? ☐ Yes ☐ No What kind? _____

Is your child taking any supplemental fluoride? ☐ Yes ☐ No If yes, how? ☐ Tablets ☐ Drops ☐ Water ☐ Vitamins

Does your child have any breathing problems? ☐ Yes ☐ No Breathes primarily through ☐ Nose ☐ Mouth

Does your child snore? ☐ Yes ☐ No

HABITS

Does your child have any of the following habits?

Thumb or finger sucking	☐ Yes ☐ No	Pacifier use	☐ Yes ☐ No	Nail biting	☐ Yes ☐ No
Lip sucking or biting	☐ Yes ☐ No	Biting hard objects	☐ Yes ☐ No	Tooth grinding	☐ Yes ☐ No

Did your child use a bottle? ☐ Yes ☐ No If yes, when did he/she stop? _____

Does your child currently use a bottle? ☐ Yes ☐ No If yes, how often during the day? _____

Is the bottle used at night? ☐ Yes ☐ No What do you put in the bottle? _____

Does your child currently nurse? ☐ Yes ☐ No

FAMILY DENTAL HISTORY

(Check appropriate parent, if yes)

Has ☐ Mother or ☐ Father had a lot of decay

Does ☐ Mother or ☐ Father have periodontal disease

Has ☐ Mother or ☐ Father had orthodontic care?

Does ☐ Mother or ☐ Father have TMJ problems?

CHILD'S DENTAL HISTORY

Has your child seen a pediatric dentist before? ☐ Yes ☐ No

If yes, the approximate month and year of last visit: _____ Where? _____

Has your child had any unfavorable experiences in a dental or medical office? ☐ Yes ☐ No

Does your child have any dental problems presently? ☐ Yes ☐ No

If yes, please explain: _____

How often does your child brush his/her teeth per day? _____ Do you help? ☐ Yes ☐ No

How often does your child floss? _____ Do you floss your child's teeth? ☐ Yes ☐ No

How do you think your child will act toward the dentist? _____

Purpose of today's dental visit? _____

Guardian's Initials _____ Date _____ Examining Doctor's Initials _____ Date _____

KARSON KUPIEC
ORTHODONTICS
AND PEDIATRIC DENTISTRY

OFFICE POLICY AND INFORMATION

Name of person completing this form: _____ Relationship to patient: _____

Please specify your preferred method of contact. _____

Appointment Policy - A parent or legal guardian must accompany the child to all appointments. If this is not possible you must inform our office prior to the appointment and request an additional consent form for the authorized adult who will be attending with your child. Unlike many other pediatric dental offices, we welcome parents and siblings to our treatment area so they can sit with their child during cleaning appointments. Because of limited space, one parent is allowed to accompany child for operative appointments.
Parents are not permitted in the treatment rooms during monitored anesthesia care (Deep Sedation) appointments.
Initials _____

Cancellation Policy - We greatly appreciate your efforts in honoring scheduled appointments and wish to provide all of our patients with the highest quality dental care in the most reasonable time possible. Please notify us 48 hours prior to your scheduled appointment if you will be unable to make it. If a patient fails or cancels two (2) scheduled appointments without 48 hours advanced notice, we will institute a broken appointment fee of $50. The fee will increase by $25 per child for each subsequent cancellation or reschedule without 24 hour notice. The fee must be settled prior to scheduling any future appointments. If you arrive more than 10 minutes after the scheduled start time for your appointment you may be asked to reschedule. **Initials** _____

Payment Policy - We accept Visa, Mastercard, Discover, Amex, Checks, and Cash to settle your portion.
Patient portion and all copays are due in full on the day services are rendered. Please be aware that the parent or guardian bringing the child to Kupiec DDS is legally responsible for payment of all charges. We cannot send statements to other persons. Accounts with past due or unpaid balances cannot schedule additional appointments until balance is paid in full. **Initials** _____

Insurance Policy - To alleviate our patients' concerns about costs of treatment, our office verifies insurance benefits online or over the phone prior to the first appointment. Upon verification we can determine eligibility and basic coverage details. We MAY NOT have access to contracted fees specific to your group plan. Please understand that we can only provide an estimate of how much your insurance might pay towards any treatment.

*A pre-authorization can be submitted at your request, but will delay treatment by approximately 6 weeks.
*Benefits quoted to our office over the-phone and online verifications are not a guarantee of payment.
*Benefits are determined upon claim submission. .
*If we do not receive payment from your insurance company within 6 weeks after submission of a claim you will be expected to pay for dental services In full.
*We cannot bill any HMO or managed care plans for services rendered at our office - we are still happy to see you.
*You must complete and sign a HIPAA form if you wish to have our office file insurance claims on your behalf. Copies of the Health Insurance Portability and Accountability Act are available upon request.

In order to file insurance claims we need the following information.

Policy holders name & date of birth: _____ ____/____/_____Relationship to patient _____

Insurance carrier/company _____ Policy holders insurance ID # or SSN _____

Please inform our office of any insurance changes at least 2 business days prior to your child's next appointment. We can not guarantee same day eligibility verification. Payment is due in full unless eligibility is verified by our office.
Initials _____
We take a picture of all our patients for their confidential file. **Initials** _____

This form is educational only, does not constiture legal advice, and covers only federal, not state law (August 14, 2022).

CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

SECTION A: PATIENT GIVING CONSENT

Name of Patient _____

Address _____

Telephone _____

_____

SECTION B: TO THE PATIENT - PLEASE READ THE FOLLOWING STATEMENTS 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, of the uses and disclosures we may make 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 complete before signing this Consent.

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 any time by contacting **Dr. Kupiec's office at 760-355-3800**.

Right to Revoke: You 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.

I, _____ , have had full opportunity to read and consider the contents of this Consent form and your 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: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT.

Include completed Consent in the patient's chart

REVOCATION OF CONSENT

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand that revocation of my consent will not affect any action you took in reliance on my consent before you received this written Notice of Revocation. I also understand that you may decline to treat or to continue to treat me after I have revoked my consent.

Signature: _____ Date: _____