for kids & teens only
ABC Dentistry
Office of Tanek L. Jenkins, DDS

Cancellation and Lateness Policy

Cancellation Policy: Do to a high demand for an appointment at our dental office, we require a confirmation for all of our dental appointment. Failure to CONFIRM for a reserved appointment **will result in a cancellation. All unconfirmed appointments will be cancelled 24 hours prior to the visit.** Patients that are being seen at our **affiliated hospital facilities** will need to give a 10 day notice to avoid a $300 cancellation fee. Due to the demand for a Saturday appointment, no show/ no confirmation for a Saturday appointment will result in our inability to guarantee another reserved Saturday appointment. **It is understandable that sometimes cancellations cannot be helped due to illness or emergency and we will take all valid circumstances into account.**

Lateness Policy: If you are late, we may not be able to complete the entire treatment. If you arrive more than 15 minutes late, your appointment may be rescheduled in order to meet the needs of those who are on time for their pre-reserved visit.

We will make all attempts to contact you, please return our call 48 hours prior to your appointment or confirm via text through our texting system. Please notify us of your telephone number or email address changing We will try to reach you with the provided means of contact failure to return our calls and confirm, will result in a cancellation so that we can provide that appoint to a patient who may be in urgent need of our care.

Email Address: _____

Additional Email Address: _____

Phone Number: _____

Additional Number: _____

I acknowledge that I have read and understood the above policies and procedures in its entirety and agree to abide by them.

Guardian Name: _____

Guardian Signature: _____

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES PATIENT CONSENT FORM

My signature confirms that I have been informed of my rights to privacy regarding my protected health information, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA). I understand that this information can and will be used to: Provide and coordinate my treatment among a number of health care providers who may be involved in that treatment directly and indirectly. Obtain payment from third-party payers for my health care services. Conduct normal health care operations such as quality assessment and improvement activities. I have been given the right to review and receive a copy of such Notice of Privacy Practices. I understand that my dental provider has the right to change the Notice of Privacy Practices and that I may contact this office to obtain a current copy of the Notice of Privacy Practices. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations and I understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Parent/Guardian Full Name: _____ Date: _____

Signature: _____ Relationship to Patient: _____

Dependent family members also covered by this acknowledgement:

Name: _____ Date of Birth _____

Additional Children/Dependants:

Name: _____ Date of Birth _____
Name: _____ Date of Birth _____
Name: _____ Date of Birth _____
Name: _____ Date of Birth _____
Name: _____ Date of Birth _____
Name: _____ Date of Birth _____

AUTHORIZATION TO RELEASE INFORMATION TO OTHERS

Many of our patients allow family members or others close to them to call and request information regarding their condition and/or treatment. Under the requirements for H.I.P.P.A. we are not allowed to give this information to anyone without the patient's consent. If you wish to have your dental condition and/or dental treatment disclosed to someone else indicate below. You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Do Not Disclose My Information to Anyone But Me ☐

You May Disclose My Information To The Following ☐

1. _____ Relationship to Patient: _____ Date: _____

2. _____ Relationship to Patient: _____ Date: _____

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Precautions During COVID – 19

In order to maintain social distancing and prevent crowding in our lobby, we ask the parents of children 5 and older to remain in their vehicles until the end of the appointment. This solution is new office policy implemented for your safety against the spread of Covid-19. We thank you for your patience during these unprecedented times. Please provide a few forms of contacts so that we are able to reach you .

Phone Number: _____

Phone Number: _____

Email: _____

Do you or a member of your family have any of the following symptoms? Please answer yes or no by putting a check mark in the box below.

Symptoms	YES	NO
FEVER		
SORE THROAT		
COUGH		
DIFFICULITY BREATHING		
BODY CHILLS		

- Only one parent is allowed in the office to check each patient in.
- Every one that enters the office must wear a mask.
- **Parents of children 5 and older must wait in the car**

My signature affirms that I have answered the questions honestly and I understand the arrival instructions. I'm willing to abide by the conditions described in the document. I acknowlede that I am brining my child to the their dental appointment on my own free will.I have had the opportunity to ask questions and have had them answered to my satisfaction.

Parent Full Name: _____

Parents Signature: _____

Date: _____

Dental History

Why did you bring the child to the dentist today? _____

_____

_____

Has the child ever taken any diet pills such as Phen-Fen? ☐ Yes ☐ No
(Also know as Redux or Pondimin.) If so, when _____

Is the child currently in pain? ☐ Yes ☐ No

Does the child require antibiotics before dental treatment? ☐ Yes ☐ No

Has the child ever had a serious/difficult problem associated with previous dental work? ☐ Yes ☐ No

Is the child's water fluoridated? ☐ Yes ☐ No

Is the child taking fluoridated supplements? ☐ Yes ☐ No

Has the child ever had any pain/tenderness in his/her jaw joint (TMJ/TMD)? ☐ Yes ☐ No

Does the child brush his/her teeth daily? ☐ Yes ☐ No

Floss his/her teeth daily? ☐ Yes ☐ No

Child's Physician: _____

Phone #: _____ Date of Last Visit: _____

Is the child currently under the care of a physician? ☐ Yes ☐ No

Please describe the child's current physical health:
☐ Good ☐ Fair ☐ Poor

Please list all prescription / over the counter or herbal supplement drugs that the child is currently taking: _____

_____

Aside from items listed, please list all drugs/things that the child is allergic to:

_____

_____

Yes No Latex Yes No Metals/Nickel Yes No Plastic

Medical History

Has the child experienced the following medical problems?

Y	N	Abnormal Bleeding / Hemophilia	Y	N	Heart Murmur
Y	N	ADD/ADHD	Y	N	Hepatitis
Y	N	AIDS/HIV +	Y	N	High Blood Pressure
Y	N	Anemia	Y	N	Hives
Y	N	Any Hospital Stays/Operations?	Y	N	Kidney Problems
Y	N	Artificial Bones/Joint/Valves	Y	N	Liver Problems
Y	N	Asthma	Y	N	Low Blood Pressure
Y	N	Cancer	Y	N	Lupus
Y	N	Chicken Pox	Y	N	Measles
Y	N	Congenital Heart Defect	Y	N	Mitral Valve Prolapse
Y	N	Convulsions	Y	N	Mononucleosis
Y	N	Diabetes	Y	N	Prosthetic
Y	N	Epilepsy	Y	N	Rheumatic Fever
Y	N	Exposed to HIV, but Neg.	Y	N	Scarlet Fever
Y	N	Handicaps/Disabilities	Y	N	Skin Rash
Y	N	Hearing Impairment	Y	N	Tuberculosis (TB)

Are the child's immunizations current? ☐ Yes ☐ No

Anything you would like to discuss with the Doctor in private? ☐ Yes ☐ No

Please discuss any serious medical problems the child experienced:

_____

_____

Does/did the child experience any of the following?

Y	N	Breast Fed	Y	N	Nursing Bottle Habits
Y	N	Chewing on Objects	Y	N	Speech Problems
Y	N	Clenching/Grinding Teeth	Y	N	Thumb/Finger Sucking
Y	N	Lip Sucking/Biting	Y	N	Tongue/Cheek Biting
Y	N	Mouth Breather	Y	N	Tongue Thrust
Y	N	Nail Biting	Y	N	Used Pacifier

Our office is HIPAA compliant and is committed to meeting or exceeding the standards of infection control mandated by OSHA, the CDC and the ADA

I affirm that the information I have given is correct to the best of my knowledge. It will be held in the strictest confidence and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

_____
Signature of Parent or Guardian Date

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ABC Dentistry
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www.ABCkidsDentistry.com

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I have verbally reviewed the medical/dental information above with the parent/guardian & patient named herein. _____
Signature of Dentist Date

Dentist's Comments: _____

Medical History Update

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N
If Yes, please explain. _____

_____

Has there been any change in your child's health status since their last visit? ☐ Y ☐ N
If Yes, please explain. _____

_____

_____
Parent/Guardian Signature Date

_____
Dentist Signature Date

_____
Parent/Guardian Signature Date

_____
Dentist Signature Date

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We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. Our practice is based on preventive care. We strive to teach good oral care that will enable your child to have a beautiful smile that lasts a lifetime.

Tell Us About Your Child

Today's Date: _____

Child's Name: _____
Last First MI

Child's Birthdate: ___/___/___ Child's Age: _____

Nickname: _____ ☐ Male ☐ Female

School: _____ Grade: _____

Hobbies: _____

Child's Home #: (____)_____ SS #: _____

Child's Home Address: _____
Apt / Condo #

_____
City State Zip

General Information

Who is accompany the child today?

Name: _____ Relation: _____

Do you have legal custody of this child ☑ Yes ☐ No

Whom may we thank for referring you? _____

Other siblings: _____

Previous / Present Dentist: _____ Last Visit Date _____

Dentists Phone #: (____)_____

Relative or Friend not living with you:

Name: _____ Phone: (____)_____

Address: _____
City State Zip

Parent's Information

Person Responsible for Account: _____ Parent's Marital Status ☐ Single ☐ Married ☐ Partnered ☐ Widowed ☐ Divorced ☐ Separated

☐ Father ☑ Step Father ☐ Guardian

Name: _____ Birthdate: ___/___/___

Address: (If different than Child's) Hm #: (____)_____

_____

_____

SS #: _____ DL #: _____

Wk #: (____)_____ Ext: _____ Cell/Other #: (____)_____

Email: _____

Employer: _____

Employer's Address _____

_____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone: (____)_____

Group # (Plan, Local, or Policy #): _____

☐ Mother ☐ Step Mother ☐ Guardian

Name: _____ Birthdate: ___/___/___

Address: (If different than Child's) Hm #: (____)_____

_____

_____

SS #: _____ DL #: _____

Wk #: (____)_____ Ext: _____ Cell/Other #: (____)_____

Email: _____

Employer: _____

Employer's Address _____

_____
City State Zip

If you have Dental Insurance Coverage for the Child, please fill out below:

Insurance Co. Name: _____

Insurance Address: _____

_____
City State Zip

Insurance Phone: (____)_____

Group # (Plan, Local, or Policy #): _____

Release

I certify that my child is covered by _____ Insurance Co. and I assign all insurance benefits otherwise payable to me. I understand that I am responsible for payment of services rendered and also responsible for paying any copayment and deductible that my insurance does not cover. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I hereby authorize the dentist to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions, whether manual or electronic.

_____
Signature of Parent or Guardian Date

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