Get Acquainted Questionnaire
Tell Us About Your Child!

Today's Date______________

Child's First Name________________________Child's Last Name___________________________Nickname___________________M F

Child's Age_______________Child's Date of Birth_______/______/______

Residence Address____City__________________________________State______

Zip_____________________Residence Phone____________________________________

Email Address____(for appointment confirmation)

School____Grade________

Please list any special interest, favorite toys, movies, etc.____

1. **Who is Accompanying the Child Today?**

Name______________________________________Relation ___________________________________

Do you have legal custody of the child? Yes___No___

Parents Marital Status: Single___Married____Widowed____Divorced___Separated____

Whom may we thank for referring you? ____

2. **Mother's Information**
Stepmother_____ Guardian____

Name_______________________Date of Birth___/___/___

Wk/ Cell #____________________Home#____________________

SS#__________________________

Present Employer____

Father's Information
Stepfather_____ Guardian ______

Name_______________________Date of Birth___/___/___

Wk/ Cell#___________________Home#_______________

SS# _________________________

Present Employer _____________________________________

3. **Person Responsible for the Account**

Name____Relation ____

Billing Address____City________________________________State_______Zip _____

Who is responsible for making appointments?

Name____Wk #___________________________Home # __________________

4. **Insurance Information**

Primary Insurance Company Name ____

Insurance Company Phone # ______________________________

Mailing Address____City__________________________State______Zip ___________

Group # __________________________________

Subscriber ID # (We must have this information to file the claim) ____

Policy Owner's Name___________________________________Policy Owner's Date of Birth____/___/___

Policy Owner's Employer ____

*** Jenkins and LeBlanc will only file primary insurance. The parent or guardian is responsible for filing secondary insurance claims. Any co-pays or co-insurance rates must be paid at the time services are rendered.**

HEALTH HISTORY QUESTIONNAIRE

Has your child had previous Anesthesia/Sedation or Surgery? YES NO
If Yes, please list:______________________________
Complications, please list: ______________________________
Does your child take medications? YES NO
If Yes, please list (include herbals): ______________________________

Does your child have any Allergies to Medications? YES NO If Yes, please list: ______________
____
Any reaction to local anesthetics (i.e. Novocain) or antibiotics? YES NO If Yes, please list: ______
____

Please answer the following questions to the best of your ability:

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING: (PLEASE CIRCLE ALL THAT APPLY)

Respiratory: Ashtma Sleep apnea Snoring Smoking Seasonal Allergies Recent Cold/Flu Frequent Ear/Tonsil Infections Sinus Tuberculosis Other:______________________________

____

Cardiovascular: Murmur Congenital Defect Rheumatic Fever High Blood Pressure Heart Attack Angioplasty/Stents Chest Pain Abnormal Heart Rhythm Other:______________

____

Liver/Gastrointestinal: Hepatitis Heartburn Ulcers Hernia Bowel/Colon Other:__________

____

Neurological/Musculoskeletal: Seizures Developmental Disability ADD/ADHD Migraines/Headaches Autism Anxiety Depression Stroke Hearing Impairment Numbness/Tingling Arthritis Back Pain Learning Disability Speech Other:______________

____

Renal/Endcrine: Diabetes Thyroid Kidney Stones Recent Weight Loss/Gain Other:________

____

Hematologic: Cancer/Chemotherapy HIV Bleeding Problems Low Blood Count

Is your child under the care of a physician for any chronic medical problems? YES NO
Please list the name of the supervising Physician responsible for your child's care:
Name:__________________________ Phone: __________________________
Address: ______________________________

DENTAL HISTORY

Last visit to a dentist: __________________________ __________________________
(Approximate date) **(Dentist Name)**

What concerns regarding your child's teeth prompted this visit?
________ I desire comprehensive dental care for my child.
________ I have specific dental concerns. My concerns are: __________________________
________ My child has complained about dental problems.
________ My child suffered an injury to the head/mouth/teeth.
If so, explain ______________________________

Has your child had any history of the following habits?
____ Thumb-sucking ____Finger-sucking ____Lip-biting ____Nail Biting ____Pacifier
Are any of these habits currently active? YES NO
Child's attitude toward dentistry: ____Favorable ____Unfavorable _____Apprehensive

I understand that the information that I have given is correct to the best of the knowledge and that it will be held in the strictest confidence. It is also my responsibility to inform the office of any changes in my child's medical status. I authorize any Dentist and/or ancillary staff of Drs. Jenkins and LeBlanc to perform the necessary dental services my child may need.

______________________________ ______________________________
(Signature of parent of guardian) **(Date)**

CONSENT FOR EVALUATION

State Law requires us to obtain your consent for any contemplated dental treatment or oral surgery. However, prior to any treatment, it is necessary to perform a thorough clinical evaluation including any diagnostic aids necessary. Please read this and ask about anything you don't understand. We will be happy to explain it.

I hereby authorize and direct Dr. Jenkins, Dr. LeBlanc, Dr. Sakima Roberts and/or other designated Associate Dentist, assisted by other dentists and/or dental auxiliaries of his/her choice to perform upon my child (or legal ward) a complete dental examination including the advisable radiographs (x-rays) and any other diagnostic aid deemed necessary by the Dentist in order to properly diagnose the dental condition of my child. I also understand that if any dental treatment is necessary, I will be required to sign consent for treatment after having been explained the proposed treatment.

GENERAL CONSENT FOR TREATMENT

State Law requires us to obtain your consent for contemplated dental treatment. This form serves as a general consent for dental treatment. Please read this form carefully and ask about anything you don't understand. We will be glad to explain it.

1. **After consultation with Dr. Jenkins, Dr. LeBlanc, Dr. Sakima Roberts and/or other designated Associate Dentist and/or dental auxiliaries and explanation about any proposed procedure, I hereby authorize and direct the treating Dentist, assisted by other Dentists and/or dental auxiliaries of his/her choice to perform upon my child (or legal ward) the following dental treatment or oral surgery procedure(s) including the necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids:**
   In general terms the dental procedures may include one or a combination of the following:
   - **Cleaning of the teeth and the application of topical fluoride.**
   - **Application of plastic "sealants" to the grooves of the teeth.**
   - **Treatment of diseased or injured teeth with dental restorations.**
   - **Replacement of missing teeth with dental prosthesis.**
   - **Removal (extraction) of one or more teeth.**
   - **Treatment of diseased or injured oral tissues (hard and/or soft).**
   - **Treatment of malposed (crooked) teeth and/or developmental abnormalities**
2. **Alternate methods of treatment, if any, will also be explained to me, as will the advantages and disadvantages of each. I am advised that though good results are expected, the possibility and nature of complications cannot be accurately anticipated and that, therefore, there can be no guarantee as expressed or implied either as to the result of the treatment or as to the cure.**

I hereby state that I have read and understand this consent, and that all questions about this consent or any planned procedures have or will be answered in a satisfactory manner prior to any treatment. I understand that I have the right to be provided with answers to questions that may arise during the course of my child's treatment. I further understand that this consent will remain in effect until such time that I choose to terminate it.

X ____ ________________
Signature of parent or guardian Date

____
Print Name

X ____
Witness

Welcome to the office of Drs. Jenkins & LeBlanc. We want to make your visit productive and enjoyable. We are happy to answer any and all questions regarding insurance plans and payment policies.

I. FINANCIAL POLICY

1. Patients WITH Insurance Coverage:
   - Please understand that your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will be glad to help you obtain the appropriate benefits from your insurance carrier as a courtesy to you. However, you are responsible for understanding you r individual benefits and for the payments of your account.
   - Regarding insurance plans where we are a participating provider, all co-pays and deductibles are due **prior to or at the time of the treatment**.
   - Regarding insurance plans where we are NOT a participating provider, estimates will be collected **prior to or at the time of the treatment** and difference will be billed as necessary.
   - If your insurance company has not paid the claim within 45 days, the balance will be automatically transferred to you.
   - In some cases, insurance carriers may pay for alternative benefits other than the treatment performed. In this case, you are responsible to pay for the difference.
   - Even if you have dual coverage there may still be a portion that is your responsibility.

2. Patients WITHOUT Insurance Coverage:
   - Patients without insurance coverage are required to pay for services rendered **at or prior to the time of treatment.**

II. CANCELLATION POLICY

- We require a 24 hour cancellation notice for a scheduled appointment.
- Patients who fail to show for their scheduled appointment without giving due notice will be charged a $35.00 fee.

III. BILLING POLICY

- Checks returned unpaid from the bank are subject to $35.00 service fee.
- Accounts delinquent more than 45 days from the date of billing are subject to a 1.5% per month (18% annually) finance charge.
- When your bill is unpaid, a collection agency may be chosen to manage delinquent accounts. If your account is sent to our collection agency you will be responsible for collection and court costs along with attorney's fees.

We accept Cash, MasterCard, Visa, and Discover, American Express or Debit/ATM cards and Care Credit

We welcome you to our office and want to provide you with the best care possible. If you have any questions regarding our policies and your treatment, please do not hesitate to ask.

BY SIGNING, I AGREE I HAVE READ AND UNDERSTAND JENKINS & LEBLANC, PA'S FINANCIAL POLICY, CANCELLATION POLICY AND BILLING POLICY AND THAT I AM THE PERSON RESPONSIBLE FOR THIS PATIENT'S ACCOUNT.

____________________________________ ________________
Signature Date

____
Printed Name

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

** You May Refuse to Sign This Acknowledgment **

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Drs. Jenkins & LeBlanc. A copy of this signed, dated Acknowledgement shall be as effective as the original.

____
Please print your name

____
Please sign your name

____
Date of your signature

If you are the legal representative of the patient, please print the patients' name(s) and describe your authority

____________________________ ________________________________
Patients Name Signor's Authority

Thank you and if you have any questions about this form or the attached Notice, please contact our privacy officer at:

Privacy Officer for
Drs. Jenkins&LeBlanc
8226 Mission Rd
Prairie Village, KS 66208
913-378-9610

Office Use Only

As privacy officer, I attempted to obtain the patient's (or representative) signature on this Acknowledgment but did not because:
It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

____
Signature of privacy officer