Phone 610-916-7600
Fax 610-916-7601

Appointment for: ____

On: ____

Time: ___________________________

Arrive 15 minutes prior to appointment time

Thank you so much for choosing our practice. Please take a few moments to carefully read the information below and complete the enclosed form, **front & back sides**. **Please bring the completed form along to your first appointment. Failure to have these forms with you and completed entirely may result in having to reschedule your appointment.**

We look forward to participating in the care of your child. We strive to make your child's visit pleasant and comfortable. Our doctors and staff have the experience and qualification to take care of your child's teeth and gums **throughout** their growth and development. Dr. Gordos and Dr. Snyder are specialized in pediatric dentistry having undergone two years of pediatric residency post dental school. Our office's goal is to teach your child oral habits that will keep their smile beautiful for a lifetime.

Pleasant visits to the dental office promote the establishment of trust and confidence in your child that will last a lifetime. Our goal, along with our staff, is to help all children feel good about visiting the dentist and teach them how to care for their teeth. From our special office designs to our communication style, our main concern is what is best for your child.

****** A few words on our practice: ******

At Berks Kids Dentistry we want to provide the most optimal care for your child. We believe that consistent care is the best way to achieve that goal. View us as the "pediatrician" for dental care. We can provide all realms of oral health care for your child including check up visits, cleanings, radiographic exams, and if need be restorative dental treatment. Once again thank you for choosing Berks Kids Dentistry. We look forward to meeting you and your child.

If your child has been seen by another dentist who has records and x-rays which may be useful to us, please have the dentist mail them to us or bring them with you to your first visit.

PLEASE UNDERSTAND THAT WE DO NOT PARTICIPATE OR HAVE A CONTRACT WITH ANY INSURANCE COMPANIES. EACH COMPANY HANDLES US DIFFERENTLY REGARDING PAYMENT, WE ARE CONCIDERED AN OUT-OF-NETWORK OFFICE WITH ALL INSURANCES.

If you have DENTAL INSURANCE, bring your dental card.
If your insurance is PA BLUE SHIELD, UNITED CONCORDIA, and DELTA DENTAL: Payment is due at appt./you will be reimbursed by the ins. co. based on your policy's coverage for an out of network office.

If your insurance is AETNA PA CHIP, ACCESS, GATEWAY, MED PLUS, MERCY or Unison: Payment is due at appt./you will NOT be reimbursed by the ins. co.

IF YOU HAVE ANY QUESTIONS ABOUT YOUR COVERAGE, PLEASE CALL YOUR INSURANCE COMPANY BEFORE YOUR APPT.

We do not participate with any insurance. You will be billed and are responsible for anything that your dental insurance company does not pay.

If you do not have dental ins.-Payment is due at appt.

We kindly ask that if you are unable to keep your appointment that you contact us a minimum of 24 hours in advance so that we may offer your appointment time to someone on our waiting list. If an appointment is missed or cancelled without proper notice your account will be charged a $25 missed appointment fee. Our aim is to open otherwise unused appointments to other patients, not to collect missed appointment fees. Your cooperation is greatly appreciated.

Feel free to call if you have any questions.
Our office is handicapped accessible.

BROKEN APPOINTMENT / CANCELLATION POLICY AND CONSENT TO TREATMENT

Welcome to Berks Kids Dentistry! We are glad you have made an appointment for yourself or your child for important oral health care. Regular dental visits every 6 months, including examinations, cleanings, fluoride treatments, dental sealants, and fillings are important to keep teeth healthy. It is especially important that you keep your appointment! Valuable time has been reserved for you or your child's care. A missed appointment results in lost time which could be used for another patient waiting to receive treatment. Below is our "BROKEN APPOINTMENT / LATE CANCELLATION POLICY".

BROKEN APPOINTMENT / CANCELLATION POLICY

If you fail to show for a scheduled appointment, **all** future appointments you may have scheduled will be cancelled, including siblings appointments. If you wish to continue your dental treatment in our office, you must call to schedule a new appointment. We also require 24 hour advanced notice when cancelling an appointment that has been reserved for you. Depending on the nature of the cancellation, any combination of failing to give adequate cancellation notice or not showing for 3 appointments will result in **DISMISSAL** from this office.

First Offense- courtesy warning
Second Offense- $25 broken appointment fee / per child
Third Offense- Dismissal from the practice

EMERGENCY CARE

Dental clients who have been dismissed from the office for either broken appointment or cancellation reasons will be notified by letter and will be seen for **EMERGENCY** care only for 30 days from the date of the dismissal letter.

CONSENT TO TREATMENT

I hereby give consent to Berks Kids Dentistry, Inc. to provide treatment to:
____, (check one) ☐ myself, ☐ my child, for those procedures and treatments, including local anesthesia, which are deemed necessary. I consent to any x-ray, examination, anesthetic, sedative, or dental treatment rendered under the general, direct, or indirect supervision of the dentist and her associates and/or staff members, as she may deem necessary.

NOTICE OF PRIVACY

Berks Kids Dentistry respects my right to privacy and confidentiality of my personal health information. I acknowledge that I have been informed of, and offered a copy of, the *Notice of Privacy Practices.*

This authorization will remain in effect until canceled in writing by me.

I have read the above policy and agree to abide by it.

__________ ____
Date Signature of Client (Parent or guardian)

__________ ____
Date Witness

Office of Dr. Kristin Gordos and Dr. Laura Snyder

MEDICAL HISTORY UPDATE

Your child's overall health as well as any medications, which your child takes, could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

YOUR CHILD

NAME___________________________
BIRTHDATE______________________
ADDRESS________________________
____
PHONE__________________________
LIVES WITH_____________________

PARENT'S INFO

MOTHER____
ADDRESS____
Home#_______________Work #___________________

FATHER____
ADDRESS____
Home#_______________Work #___________________

Marital Status ________________________________

DENTAL INSURANCE:____

MEDICAL HISTORY

CHILD'S PHYSICIAN____
DATE OF LAST VISIT_______________ REASON______________________________

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING:

ASTHMA	□ yes □ no	DIABETES	□ yes □ no
CANCER	□ yes □ no	AIDS / HIV	□ yes □ no
HANDICAPS/ DISABILITIES	□ yes □ no	SEIZURES / EPILEPSY	□ yes □ no
AUTISM	□ yes □ no	ABNORMAL BLEEDING	□ yes □ no
CONGENITAL HEART DEFECT	□ yes □ no	ADD / ADHD	□ yes □ no
HEART MURMUR	□ yes □ no	ALLERGY	□ yes □ no
TYPE______________________		TYPE______________________	

OTHER (please explain):
____
MEDICATIONS:
____

Please explain any medical problem that your child has:______________________________
____
____

CONSENT FOR TREATMENT

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize Dr. Gordos, Dr. Snyder, and staff to perform any and all necessary routine dental diagnostic procedures for my child. If I accept the proposed treatment plan, I agree to the use of anesthetics considered necessary or advisable by the dentist for the comfort and well- being of my child. I understand that I am responsible for **ALL** fees regardless of insurance coverage and that I intend to pay **all charges** incurred at this office for dental services.

Parent or Legal Guardian_X_________________________________Date____________

WELCOME TO THE OFFICE OF

BERKS KIDS DENTRISTY

DR. KRISTIN GORDOS and DR. LAURA SNYDER

DENTISTRY FOR CHILDREN AND ADOLESCENTS

We strive to make each of your child's visits pleasant and comfortable.
Our goal is to teach your child oral habits that will help
keep their smile beautiful for their lifetime.

*******PLEASE TAKE THE TIME TO COMPLETE THESE FORMS ENTIRELY.*******

PATIENT INFORMATION

Name __________________________________Nickname ____________________

Address ____

City _____________________State ___________________Zip Code__________

Home Phone # __________________

Birth Date _______ Age ____ Sex: M__ F__ Social Security # _______________

Patient Lives With ________________________________

PARENT/GUARDIAN INFORMATION

Mother __ Stepmother__ Guardian__

Name ______________________________

Address ____

City__________________________ State ____________________ Zip Code_________

Home Phone___________________ Cell Phone # ______________________

Employer______________________ Work #___________________________

Birth Date_________________ Social Security#____________________

Father__ Stepfather__ Guardian__

Name ______________________________

Address ____

City__________________________ State ____________________ Zip Code_________

Home Phone___________________ Cell Phone # _____________________

Employer______________________ Work #___________________________

Birth Date_________________ Social Security#____________________

Parents Marital Status _______________

DENTAL INSURANCE INFORMATION

Policy Holders Name ________________________________Social Security #_______________

Employer _________________________

Insurance Company_________________________________ Group #_____________

Claims Address____

******Please be aware that we file insurance as a **COURTESY** to our patients. If any of the above information is not completed we may not be able to assist you with you Dental Insurance claims. We are not responsible for how your insurance company handles the claims or what benefits you plan covers. It is best to call your insurance with any coverage questions. We can only assist you with any questions regarding coverage.

(CONTINUED ON OTHER SIDE)

HEALTH HISTORY

Your child's overall health as well as any medications, which your child takes, could have an important inter-relationship with the dental care your child receives. Please answer each of the following questions completely.

MEDICAL HISTORY

CHILD'S PHYSICIAN________________________

DATE OF LAST VISIT______________________

REASON_________________________________

HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING:

ADD/ADHD ☐ yes ☐ no

ASTHMA ☐ yes ☐ no

DIABETES ☐ yes ☐ no

CANCER ☐ yes ☐ no

AIDS / HIV ☐ yes ☐ no

HANDICAPS ☐ yes ☐ no

DISABILITIES

SEIZURES / EPILEPSY ☐ yes ☐ no

AUTISM ☐ yes ☐ no

ABNORMAL BLEEDING ☐ yes ☐ no

CONGENITAL HEART DEFECT ☐ yes ☐ no

HEART MURMUR ☐ yes ☐ no

TYPE___________________________________

ALLERGY ☐ yes ☐ no /Explain________________

Please explain any medical problem that your child has:_____________________________________

____

Any unfavorable reaction to Medicine or Drugs, and if so what?__________________________________

____

Medications currently taking___________________

____

DENTAL HISTORY

DATE OF LAST DENTAL VISIT_________________

WAS IT A FAVORABLE ONE?___________________

PREVIOUS DENTIST__________________________

REFERRED BY _____________________________

Are there any dental problems you would like to make the dentist aware of?________________________

____

HISTORY OF TOOTHACHE ☐ yes ☐ no

LOCATION______________________________

HISTORY OF TOOTH INJURY ☐ yes ☐ no

LOCATION AND WHEN _____________________

IS YOUR CHILD'S WATER FLUORIDATED? ☐ yes ☐ no

DOES YOUR CHILD TAKE FLUORIDE SUPPLEMENTS? ☐ yes ☐ no

DOES YOUR CHILD:

SUCK THUMB/ FINGER ☐ yes ☐ no

Age stopped____________________

MOUTH BREATHER ☐ yes ☐ no

USE PACIFIER ☐ yes ☐ no

Age stopped_____________________

USE BOTTLE ☐ yes ☐ no

Age stopped_____________________

GRIND TEETH ☐ yes ☐ no

CONSENT FOR TREATMENT

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize Dr. Gordos, Dr. Snyder and staff to perform any and all necessary routine dental diagnostic procedures for my child. If I accept the proposed treatment plan, I agree to the use of anesthetics considered necessary or advisable by the dentist for the comfort and well being of my child. I understand that I am responsible for **ALL** fees regardless of insurance coverage and that I intend to pay **all charges** incurred at this office for dental services.

Parent or Legal Guardian____ ***Date***___________

SIGNATURE

KRISTIN GORDOS, D.M.D.

LAURA SNYDER, D.M.D

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I, ________________________________, have received a copy of this office's Notice of Privacy Practices. (Parent)

____
{Please Print Name} (Child)

____
{Signature} (Parent)

____
{Date}

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communications barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

____

____

____

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Reproduction and use of this form by dentists and their staff is permitted. Any other use, duplication or distribution of this form by any other party requires the prior written approval of the American Dental Association.

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).

Dental Emergencies:

Dental emergencies happen every day in our practice. Please contact our office if there is a dental emergency for your child that you feel needs urgent care. Here are several scenarios of dental emergencies and what you can do as a parent.

Toothache: If your child is complaining of a toothache rinse the area gently and dislodge any food that may be impacted. If your child is still in pain, please contact our office right away. Please do not place aspirin or warm compresses on the gum or the tooth in pain. If your child has a swelling, place ice packs on the area in question and call our office immediately.

Abscess: A dental abscess in a primary tooth appears as a small swelling or bubble on the gum. Abscesses most commonly occur when the nerve (pulp) of the tooth becomes infected with bacteria, or when trauma to the teeth has occurred. An abscessed tooth can be painful or sensitive. In primary teeth the course of treatment is extraction, and in permanent teeth the course of treatment is Root canal therapy or extraction. Antibiotics are often prescribed when an abscess is present. Please call our office if you notice an abscess in your child's mouth.

Cut or bitten Tongue, Lip or Cheek: This adverse event most often occurs after your child has been at the dentist and is numb and has started biting their lip tongue or cheek. To control swelling that may occur, place ice packs. If there is bleeding also, hold gauze on the area with firm pressure.

Knocked out permanent tooth: If at all possible, try to find the tooth. Handle the tooth by the crown and not by the root. DO NOT clean, scrub or handle the tooth unnecessarily. If the tooth is not fractured, try to reinsert the tooth into its socket, have your child bite down on gauze and contact us immediately. If you cannot reinsert the tooth, place the tooth in milk and contact us immediately. Your child needs to be seen immediately by a dentist in order to save the tooth.

Knocked out baby tooth: If at all possible try to find the tooth, BUT DO NOT PLACE THE TOOTH BACK IN THE MOUTH. Baby teeth are not placed back in the mouth, because they can adversely affect the developing permanent tooth. If your child's tooth does get knocked out, please contact our office. If your child is bleeding have them bite down on gauze. To prevent swelling ice packs can be placed on the affected area.

Chipped or fractured permanent tooth: Contact our office immediately. Quick action can save the tooth from infection, and prevent the need for extensive dental treatment.

Chipped or fractured baby tooth: Contact our office. The extent of the fracture will indicate the treatment necessary for your child.

Severe blow to the head: Go to the closest emergency room immediately

Possible broken or fractured jaw: Limit movement of the jaw, and take your child to the closest emergency room.