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.

The enclosed paperwork must be completed in full and brought with you to your appointment. Failure to have these forms with you and completed entirely may result in having to reschedule your appointment.

Payment:

PAYMENT IS DUE AT THE TIME OF THE APPOINTMENT.
We accept Visa, MasterCard, Discover, cash or check.

We do not accept American Express.

Insurance information:

PLEASE UNDERSTAND THAT WE DO NOT PARTICIPATE WITH ANY INSURANCE COMPANIES. WE ARE CONSIDERED AN OUT-OF-NETWORK OFFICE WITH ALL INSURANCES.

IF YOU HAVE DENTAL INSURANCE AND HAVE ANY QUESTIONS ABOUT YOUR INSURANCE COVERAGE, PLEASE CALL YOUR INSURANCE COMPANY BEFORE YOUR APPOINTMENT.

If you have DENTAL INSURANCE, bring your dental insurance information and/or card with you to your appointment.

Office information:

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. The goal of our office 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.

We 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.

Our office is handicapped accessible.

We look forward to meeting you at your upcoming appointment!

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 (3 PAGES) *******

Failure to have these forms with you and completed entirely may result in having to reschedule your appointment.

PATIENT INFORMATION

Name _____Nickname _____
Address _____
City _____State _____Zip Code_____
Preferred Phone # _____ Alternate Phone # _____
Birth Date _____ Age ____ Sex: M__ F__ Social Security # _____
Patient Lives With _____
Contact E-mail address _____

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 _____

******Please be aware that we **help** file insurance as a **COURTESY** to our patients. If any of the following 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 your plan covers. It is best to call your insurance with any coverage questions. We can only assist you with any questions regarding coverage.

We do not participate with any insurance. You are responsible for any charges regardless of your dental insurance coverage.

DENTAL INSURANCE INFORMATION

Policy Holders Name _____Social Security #_____
Employer _____
Insurance Company_____ Group #_____
Claims Address_____

__ No Dental Insurance

Patient Name: _____

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_____
_____
Any unfavorable reaction to Medicine or Drugs, and if so what?_____
Please explain any medical problem that your child has:_____
_____
_____
Medications currently taking_____
_____

DENTAL INFORMATION

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_____
USE PACIFIER □ yes □ no
Age stopped_____
BREAST FED □ yes □ no
Age stopped_____
USE BOTTLE □ yes □ no
Age stopped_____

DENTAL HISTORY

IS THIS YOUR CHILD'S 1ST DENTAL VISIT □ yes □ no
If **NO** please answer the following questions:
DATE OF LAST DENTAL VISIT_____
WAS IT A FAVORABLE ONE? _____
PREVIOUS DENTIST_____
REFERRED BY _____
Reason for today's appointment_____
_____
_____
HISTORY OF TOOTHACHE □ yes □ no
LOCATION_____
HISTORY OF TOOTH INJURY □ yes □ no
LOCATION AND WHEN _____

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

For office use only: Reviewed by _____

Rev 2/2016

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 (copy available upon request)

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)

I give my consent that photos or video of me/my child can be taken for use on the Berks Kids Dentistry web site and/or social media site. I understand that if patients are identified, ONLY the first name will be used.

__ Yes, you may photograph and use my photos.

__ No, please do not photograph.

_____ _____
Date Signature of Client (Parent or guardian)

For office use only- Date: _____ Reviewed by: _____

Rev.11/16