



# Dentistry for Children & Adolescents, Ltd.

Dr. Kala Hinz  
Dr. Vera Kenderian  
Dr. Neha Sethi

Dear Parents and Guardians,

Welcome to your child's new dental home! We are experienced and caring health care professionals who will guide your child through age appropriate dental health care instruction, supervision of growth and development, and preventive measures to prepare your child for a lifetime of excellent oral health.

Please complete the enclosed forms and bring them with you to your child's first visit. It is important that these forms are thoroughly completed prior to the visit so our clinical staff can evaluate your child's individual needs when you arrive. You will have enough time at the beginning of the appointment to ask any questions that you may have regarding this packet of information.

If you have any other questions regarding your child's first appointment, please call the office. We look forward to meeting you and serving your child's dental health care needs.

Sincerely yours,

*Kala Z. Hinz, DDS, MS*  
Dr. Kala Hinz

*[Signature]*  
Dr. Vera Kenderian

*Neha Sethi, DDS*  
Dr. Neha Sethi



Today's Date \_\_\_\_\_ Acct. # \_\_\_\_\_

Child's Full Name \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Nickname \_\_\_\_\_ Adopted: Yes \_\_\_\_\_ No \_\_\_\_\_ School \_\_\_\_\_

Financially Responsible Parent or Guardian (Print name) \_\_\_\_\_

Signature of Financially Responsible Parent or Guardian \_\_\_\_\_

**Mr./Mrs./Ms./Dr.**

**Parent's Name** \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ S.S. # \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Dental Insurance: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, insurance company \_\_\_\_\_ Group # \_\_\_\_\_

**Mr./Mrs./Ms./Dr.**

**Parent's Name** \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ S.S. # \_\_\_\_\_

Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Work Phone \_\_\_\_\_ Ext. \_\_\_\_\_

Dental Insurance: Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, insurance company \_\_\_\_\_ Group # \_\_\_\_\_

**Email to confirm appointments** \_\_\_\_\_

Parent's Marital Status: Single \_\_\_\_\_ Married \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_ Other \_\_\_\_\_

Do we see other children in your family? If yes, please name \_\_\_\_\_

In case of emergency (if we are unable to reach the child's parents): Name \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_ Relationship \_\_\_\_\_

**RELEASE**

I authorize dental health care for my minor child, \_\_\_\_\_, to be performed by Dr. Kala Hinz, Dr. Vera Kenderian, and/or Dr. Neha Sethi. I understand that, if my child is ineligible for dental insurance, MinnesotaCare or state assistance on the service date, I will be responsible for payment of all charges.

Parent or Guardian's Signature \_\_\_\_\_ Date \_\_\_\_\_

*Thank you for taking the time to complete the above personal history.*

**Dr. Kala Hinz, Dr. Vera Kenderian, and Dr. Neha Sethi**

# HEALTH HISTORY

Patient's Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Medical Physician's Name: \_\_\_\_\_ Location: \_\_\_\_\_

Specialists (if applicable): \_\_\_\_\_ Date of last physical examination: \_\_\_\_\_

Has your child ever been hospitalized? yes no If so, when and why? \_\_\_\_\_

Is your child taking any medications? yes no If yes, please list medications and dosage: \_\_\_\_\_

Allergies: \_\_\_\_\_ Allergies to Medications: \_\_\_\_\_

Are your child's immunizations up-to-date? yes no

Does your child have any unusual fears? \_\_\_\_\_

## DOES YOUR CHILD HAVE OR HAS YOUR CHILD EVER HAD ANY OF THE FOLLOWING CONDITIONS:

(Please circle the correct response.)

Adverse drug reaction	Yes	No	Diabetes	Yes	No	Muscular dystrophy	Yes	No
Anemia	Yes	No	Down syndrome	Yes	No	Pregnancy	Yes	No
Asthma	Yes	No	Emotional problems	Yes	No	Premature birth	Yes	No
Ataxia	Yes	No	Fainting spells	Yes	No	# weeks gestation _____		
Attention deficit disorder	Yes	No	Headaches	Yes	No	Psychiatric problems	Yes	No
Autism	Yes	No	Hearing loss/impairment	Yes	No	Rheumatic fever	Yes	No
Birth defects	Yes	No	Heart condition/murmur	Yes	No	Seizures	Yes	No
Bleeding problems	Yes	No	Hepatitis	Yes	No	Sexually transmitted disease	Yes	No
Blood transfusions	Yes	No	Herpes	Yes	No	Sickle cell anemia	Yes	No
Date _____			High blood pressure	Yes	No	Skin disorders	Yes	No
Cancer	Yes	No	HIV/AIDS	Yes	No	Speech problems	Yes	No
Cerebral palsy	Yes	No	Infections (recurrent)	Yes	No	Spina bifida	Yes	No
Chronic ear infections	Yes	No	Jaundice (not at birth)	Yes	No	Tuberculosis	Yes	No
Cognitive delay	Yes	No	Kidney disease	Yes	No	Tumors	Yes	No
Cystic fibrosis	Yes	No	Latex allergy/sensitivity	Yes	No	Vision problems	Yes	No
Delayed speech dev.	Yes	No	Learning disabilities	Yes	No			
Development delay	Yes	No	Liver disease	Yes	No			

Please explain all "yes" responses.

Please list any other problems/conditions we should be aware of prior to treatment: \_\_\_\_\_

Signature

Relationship to Child

Date

Patient Name \_\_\_\_\_

Reason for today's visit \_\_\_\_\_

Whom may we thank for referring your child? \_\_\_\_\_

Has your child seen a dentist previously?  yes  no

Name and location of dentist \_\_\_\_\_

Date of most recent exam \_\_\_\_\_ Date of most recent x-rays \_\_\_\_\_

Was the experience  favorable  unfavorable?

How do you feel your child will react to this dental visit?  
 cooperative  uncooperative  unsure

Was your child breast fed?  yes  no If yes, for how long? \_\_\_\_\_ months

At what age was bedtime nursing discontinued? \_\_\_\_\_ months

Was your child bottle fed?  yes  no If yes, for how long? \_\_\_\_\_ months

At what age was the bedtime bottle discontinued? \_\_\_\_\_ months

Contents of the bedtime bottle \_\_\_\_\_

Has your child sucked his or her fingers or thumb?  yes  no If yes, for how long? \_\_\_\_\_ years

Has your child used a pacifier?  yes  no If yes, for how long? \_\_\_\_\_ years

Does your child grind his or her teeth?  yes  no

Is your child a mouth breather?  yes  no

Has your child had any injuries to his or her teeth?  yes  no

If yes, describe \_\_\_\_\_

How often does your child brush his or her teeth? \_\_\_\_\_

How often do you assist your child with toothbrushing?

Is your child using fluoride toothpaste \_\_\_\_\_ or non-fluoride toothpaste \_\_\_\_\_?

Does your child like to brush his or her teeth?  yes  no

Do you floss your child's teeth? \_\_\_\_\_ How often? \_\_\_\_\_

What is your child's primary source of drinking and cooking water?  
 city water  well water  bottled water  filtered water (type of filter \_\_\_\_\_)

Does your child currently receive any of the following fluoride supplements?  
 Fluoride drops or tablets  vitamin/fluoride combination  
 home rinse (over the counter)  home use gel (prescription)

Has your child ever complained of any of the following?  
 toothache  jaw joint pain (TMJ)  
 teeth sensitive to hot/cold  frequent headaches

Do you have any special concerns about your child or is there anything else we should know about your child prior to initiating dental care? \_\_\_\_\_

Thank you for completing this personal dental history for your child. The information which you provide allows to more appropriately plan for your child's emotional and dental needs while making a thorough evaluation of your child's dental health.

I hereby certify the foregoing information is true and correct.

Signature of parent/guardian \_\_\_\_\_ relationship \_\_\_\_\_ date \_\_\_\_\_

# DENTAL HISTORY



# Dentistry for Children & Adolescents, Ltd.

Dr. Kala Hinz  
Dr. Vera Kenderian

## FINANCIAL POLICY FOR DENTAL SERVICES

### For families who have dental insurance (for preventive appointments):

\*As a courtesy, we will submit dental claims to your insurance. Once the insurance company pays, we will send you a billing statement that is due upon receipt for services not covered.

### For families who have dental insurance (for restorative appointments):

\*As a courtesy, we will submit a pre-treatment estimate to your insurance company to determine what they will cover. At your child's restorative appointment, we will collect from you any patient responsibility that is owed based on the pre-estimate. If you have specific questions about coverage, please contact your insurance company.

### For families who have reimbursement plans or that do not carry dental insurance:

\*Payment is due the date of service. For your convenience, payments can be made using Cash, Check, Visa, MasterCard, Discover and Care Credit.

### Accounts over 90 days past due are subject to collection action.

\*If you need financial arrangements, please contact us and we will be happy to assist you with one of the payment options we can offer your family.

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date



# NOTICE OF PRIVACY PRACTICES

---

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.  
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

---

## OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on 4/14/03, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

---

## USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

**Treatment:** We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

**Payment:** We may use and disclose your health information to obtain payment for services we provide to you.

**Healthcare Operations:** We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

**Your Authorization:** In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

**To Your Family and Friends:** We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

**Persons Involved In Care:** We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

**Marketing Health-Related Services:** We will not use your health information for marketing communications without your written authorization.

**Required by Law:** We may use or disclose your health information when we are required to do so by law.

**Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Dentistry for Children and Adolescents, Ltd.

## CONSENT FOR USE & DISCLOSURE OF HEALTH INFORMATION

Parent/Guardian: \_\_\_\_\_ Patient Name \_\_\_\_\_

Address: \_\_\_\_\_

**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. The Notice provides a description of 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.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we make changes, we will issue a revised Notice of Privacy Practices. 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, at anytime by contacting:

**Office Administrator**  
**(507) 288-8060 or fax (507) 288-3344**  
**2743 Superior Drive NW**  
**Rochester, MN 55901**

**RIGHT TO REVOKE:** You have the right to revoke this Consent at any time by giving us written notification 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. However, we may decline to treat you, or to continue treating you, if you revoke this Consent.

### SIGNATURE:

I, \_\_\_\_\_, have had the opportunity to read and consider the contents of this Consent form and the 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 signed by parent/guardian/or 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.  
Completed copy is included in the patient's chart.

**USE OF THIS FORM IS REQUIRED BY THE STATE OF MINNESOTA.**

### **Late Arrival and No-Show Policy**

One of our main goals at Dentistry for Children and Adolescents is to make your child's visit a pleasurable one. In our effort to make each visit more comfortable and to minimize wait time, our office has implemented a late arrival policy. If a patient is more than 5 minutes late for an appointment, the appointment may need to be rescheduled. This is to ensure that your child receives the quality dental care he/she deserves and that the patients who arrive on time, do not wait longer than necessary to see the provider. You may be given the option to wait for another appointment time on the same day, if one is available. We will try to accommodate late-comers as best as possible, but cannot compromise on the quality and timely care provided to your child. New patients are encouraged to arrive at the office at least 10 minutes prior to the scheduled appointment to complete the paperwork. If a new patient's paperwork is not completed in a timely fashion upon arrival, we may need to accommodate other patients who arrive on time.

We understand that your plans might change and emergencies happen, so if for any reason you believe that the scheduled appointment(s) might not work for your child please kindly inform us no later than 24 hours before the scheduled appointment. If your family misses or does not show up for two consecutive scheduled appointments in a six-month period, your family may be dismissed from our practice.

**We truly appreciate your compliance and understanding with this policy so that we can continue to provide excellent healthcare, as well as excellent customer service.**

Your signature: \_\_\_\_\_

Date: \_\_\_\_\_

## PERMISSION FORM

I, \_\_\_\_\_mother/father/legal guardian **GIVE / DO NOT GIVE** (circle one)  
my permission for Dentistry for Children and Adolescents, Ltd. to communicate and share  
information regarding appointments, treatment planning, and financial arrangements with the  
following individual(s) when parent or guardian is not present.

NAME	RELATIONSHIP TO PATIENT
NAME	RELATIONSHIP TO PATIENT
NAME	RELATIONSHIP TO PATIENT

Regarding the following patient (s):

PATIENT'S NAME
PATIENT'S NAME
PATIENT'S NAME

I have read and understand the conditions of the form. The permission is valid unless revoked  
by legal guardian or Dentistry for Children and Adolescents, Ltd.

Signature of parent/legal guardian: \_\_\_\_\_

Date: \_\_\_\_\_