Dr. Ryan Basler DDS
Dr. Nathan van Hofwegen DDS
621 West Centre Ave, Portage, MI 49024
Phone (269)343-5386 Fax (269)343-0913
kzoopd@gmail.com

Child's full name_____Age_____Birthdate_____ Sex F M

Name child goes by_____ Child's Social Security # _____

Child's Address_____City_____Zip_____

Current Family Dentist_____

Do parents live together? Yes ___ No ___ If not, with whom does the child live?_____

PARENT/GUARDIAN INFORMATION

Name_____ DOB _____ SSN _____

Home Address_____City_____Zip_____

Relationship to the child_____Employer_____

Home Phone_____ Mobile _____Email_____

Marriage Status: ___ Single ___ Married ___ Divorced Spouses Name: _____

PARENT/GUARDIAN INFORMATION

Name_____ DOB _____ SSN _____

Home Address_____City_____Zip_____

Relationship to the child_____Employer_____

Home Phone_____ Mobile _____Email_____

Marriage Status: ___ Single ___Married ___ Divorced Spouses Name: _____

Emergency Contact Name _____Phone Number_____

Relationship to the child_____

Our office communicates with our patients electronically, via e-mail and text messaging for appointment reminders. Please inform us of your preference of communication:

____E-mail address_____

____Text Message (Mobile)_____

____Phone Call Reminder

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Today's Date_____ **Childs Name**_____ **DOB**_____

CHILD'S MEDICAL HISTORY

Please check any of the following medical conditions your child has experienced. Please circle if there's more than one option:

___Asthma	___ Seizures/Epilepsy	___ Latex Allergy
___ Anemia	___ Heart Condition	___ Speech/Vision Problems
___ Hepatitis	___ Liver Problems	___ Down syndrome
___ Abnormal Bleeding	___ Nose/Throat Disorder	___ Autism /Asperger's
___ Blood Disease	___ Tonsils/Adenoids Removed	___ Anxiety/Nervous Disorder
___ Diabetes	___ Cancer/Tumors	___ ADD/ADHD
___ Skin Disorder	___ Stomach/Kidney Problems	___ Emotional/Behavioral Disorder
___ Ear Problems	___ HIV/AIDS	___ Other_____

Name and phone number of child's pediatrician or physician_____

Has your child been hospitalized since birth? Yes___ No ___ If yes, please explain_____

_____

Is your child allergic to any medications or foods? Yes___ No ___ If yes, please explain_____

Is your child presently taking any medication? Yes___ No ___ If yes, explain_____

Does your child need to take medication prior to dental treatment including heart related medications? Yes___ No ___

If yes, please list medication(s)_____

CHILD'S DENTAL HISTORY

Is your child on a bottle? Yes___ No ___ If no, at what age was it discontinued_____

Is your child a thumb sucker or ever used a pacifier? Yes___ No ___ If no, at what age was discontinued_____

Is your primary source of water from a well? Yes___ No ___

Has your child ever been seen by a dentist? Yes___ No ___

If so, please give the date and place of last dental care: _____

Has your child had problems with previous dental treatment? Yes___ No ___

If yes, please explain _____

Has your child had any type of injury to his/her teeth? Yes___ No ___

If yes, please explain _____

Is your child in pain today? Yes___ No ___ Is it due to an injury? Yes___No

How long?_____

Does your child have a dental condition about which you are especially concerned? Yes___ No ___

If yes, please explain_____

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Written Financial Policy

Thank you for choosing Dr. Ryan Basler and Dr. Nathan van Hofwegen to treat your child's dental needs. Our practice is continually working as a team to realize a shared vision of uncompromising excellence in dentistry.

We do ask that you are aware of your dental plan coverage, however, we are in network for Delta Dental Premier as well as Healthy Kids Delta Dental and we will courtesy bill most other insurance carriers as an out of network provider. If there is a balance in which your insurance does not cover, you are responsible for the remaining amount. Payment options include: Cash, Check, Visa, Mastercard, Discover and Care Credit.

Whomever is bringing your child to their dental appointments, we consider them the responsible party for the financial portion of the visit regardless if you are the insurance carrier or not.

Date: _____ Patient's Name_____

Signature: _____ Print Name: _____

Responsible Party Insurance Information

Name of Primary Subscriber: _____ Social Security Number: _____

DOB: _____Name of Primary Dental Insurance: _____

Group Number: _____Member/Enrollee ID: _____

Customer Support/Provider Phone Number: _____

Name of Secondary Subscriber: _____ Social Security Number: _____

DOB: _____Name of Primary Dental Insurance: _____

Group Number: _____Member/Enrollee ID: _____

Customer Support/Provider Phone Number: _____

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HIPAA Acknowledgment of Receipt of Notice of Privacy Policies-Minor Child

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices. Existing Michigan Law requires (in addition to our attempt to obtain your written acknowledgment, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; a licensure investigation; or a child abuse/neglect investigation.

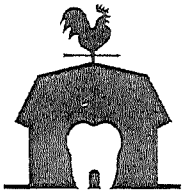
From time to time it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another dentist or other health care professional, or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Acknowledgement of Policy

I have received/was offered a copy of the Notice of Privacy Practices of Kalamazoo Pediatric Dentistry. I hereby authorize, as indicated by my signature below, Kalamazoo Pediatric Dentistry to use and to disclose my protected health information for any necessary clinical, financial, and insurances purposes, as authorized in the Consent to Treat form.

Date_____ Patient Name_____

Guardian Signature_____ Relationship to the Child_____



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I hereby authorize and direct Dr. Ryan Basler and/or Dr. Nathan van Hofwegen and staff to perform upon my child all necessary dental treatment as agreed upon between the doctor and myself; including the use of any necessary local anesthesia, radiographs, cleaning of the teeth and application of fluoride, application of sealants, removal of one or more teeth, treatment of diseased or injured oral tissues (hard and/or soft), pulp treatment to one or more teeth, repositioning of one or more teeth and/or oral development or growth abnormalities, replacement of missing teeth with dental prosthesis, treatment of diseased or injured teeth with dental restorations or crowns.

I understand the purpose and nature of these procedures and any alternate procedure or methods, if any, have been explained to me as well as the advantages and risks associated, as well as the prognosis if no treatment is provided.

I agree to the use of local anesthesia and/or the use of nitrous oxide/oxygen analgesia at the judgement of the doctor preforming the dental procedure. I understand that there is no guarantee that the dental procedures will be successful, however, the procedures are desired and intended to result in improved oral condition.

I have been informed that the success of the dental treatment to be provided will require that the patient and/or legal guardian(s) follow the post-care instructions provided by this office.

I also authorize the doctors to use photographs, radiographs, other diagnostic materials and treatment records for the purpose of teaching, research, and scientific publications.

I hereby state that I have read and understand this consent and all questions have been answered in a satisfactory manner. If there are further questions that may arise, I have the right to be provided with answers to questions that may arise during the course of my child's treatment. I also understand that I can withdraw my consent to treatment at any time and that this consent will remain in effect until such time that I choose to terminate it.

Date:_____ Patient's Name_____

Name of Parent/Guardian_____ Relationship to Patient_____

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Guardian Consent Form

I, _____, hereby give permission to the following to bring my child/children into Kalamazoo Pediatric Dentistry for their dental care needs:

Name_____ Relationship to child/children_____

Name_____ Relationship to child/children_____

Name_____ Relationship to child/children_____

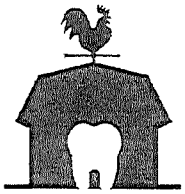
Child/children name(s):_____

_____ I authorize them to make decisions regarding the need for treatment and to schedule future appointments for such treatment. I understand that I am financially obligated to any treatment that they approve or bring my child/children to Kalamazoo Pediatric Dentistry for.

Signature: _____ Date: _____

_____ I do not authorize the above person to make any decisions regarding treatment needs or to schedule future appointments for my child/children.

Signature: _____ Date: _____



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No Show and Cancellation Policy

If you need to cancel or reschedule your appointment with us, we expect you to contact our office at least 24 hours in advance. This allows us the opportunity to fill that appointment time as well as determining another appointment time for you child.

Our office will attempt to contact you via phone call, text and/or email before your scheduled appointment to confirm your visit with us. If we are unable to speak with you a message will be left for you.

If we do not receive a call at least 24 hours in advance or if you fail to show, this may result in the following:

- A $50 fee may be assessed to your account
- We reserve the right to dismiss your family from our practice

Definition of a no show or same day cancellation appointment includes: not showing for an appointment, not calling at least 24 hours in advance, or arriving more than 15 minutes after your scheduled appointment time.

Patient Name_____ Date_____

Signature_____ Print Name_____