Patient Information

Child's First and Last Name:_____
Name Child Prefers to be Called: _____
Social Security #: _____ Sex: F M Date of Birth: _____/_____/_____
Street Address: _____ Apt.# _____
City: _____ State: _____ Zip Code: _____

Parent/ Legal Guardian Information

Name: _____
Relationship to Child: _____
SS#: _____
Date of Birth: _____
Driver's License #: _____
Employer: _____
Cell #: _____
Home #: _____
Email Address: _____

Name: _____
Relationship to Child: _____
SS#: _____
Date of Birth: _____
Driver's License #: _____
Employer: _____
Cell #: _____
Home #: _____
Email Address: _____

Please provide an email address to receive reminders of your upcoming appointments.

Emergency Contact (Nearest Friend/Relative Not Living With You)

Name: _____ Phone: ( ) _____
Address: _____
Relationship to Child: _____

Preferred Pharmacy – *any prescriptions made by our office will be sent to the pharmacy indicated below*
Name: _____ Phone Number: _____
Address: _____

How Did You Hear About Us? (Please circle all that apply)

Friend/ Relative: _____
Physician/Dentist: (please list who): _____
Advertisement: Drive By Internet Postcard Other: _____
Other (please list): _____

MEDICAL HISTORY

Patient Name:_____ DOB: _____

Child's Physician: _____ Phone#:_____Date and Reason of Last Exam: _____

Child's Specialist: _____ Phone#:_____Date and Reason of Last Exam: _____

Please Mark Each Item "Y" or "N" as It Relates to Your Child:

Y N Heart Murmur/ Heart Problems
Y N Seasonal Allergies
Y N Asthma Date of Last Attack: _____
Y N ADD/ADHD
Y N HIV+/ AIDS
Y N Liver Problems
Y N Kidney Problems
Y N Cancer

Y N Convulsions/Epilepsy
Y N Diabetes
Y N Physical Impairment
Y N Mental Impairment/ Developmental Delay
Y N Autism
Y N Abnormal Bleeding
Y N Premature

Y N Are your child's immunizations/vaccines up to date? If not, please explain: _____
_____

Y N Allergies to any Medications, Latex, or other Products/ Foods? If Yes, Please List: _____
_____

Y N Currently taking ANY prescription/non-prescription medication(s) or dietary/herbal supplement(s), including vitamins? If yes, please list all, including reason why, and the prescribing doctor's name:
_____

Y N Any other medical issues not listed above: _____

Y N Any Hospitalizations/ Surgeries If Yes, Please List: _____

Y N Prosthetic Devices, Pins, Screws If Yes, Please List: _____

DENTAL HISTORY

Date of Last Dental Visit: _____ Were X-rays taken? _____

Chief Concern for this Visit: _____

Y N Has your child ever had an unfavorable dental/medical visit? If yes, please explain:
_____

Y N Has your child ever had any injuries to the head, teeth, or mouth? If yes, please explain:
_____

Y N Does your child have any habits (grinding, thumb/finger/pacifier sucking, mouth breathing, etc)?

Y N Has your child complained of discomfort with jaws? If yes, please explain: _____

How often does your child brush? _____ Floss? _____

Do you help your child brush? Y N Do you help your child floss? Y N

Does your child use fluoridated toothpaste? Y N

How often does your child snack? _____ How often does your child drink? _____

Most frequent snack(s): _____ Most frequent drink(s): _____

Y N Any family history of tooth/gum problems or missing/extra teeth? Please explain: _____

AUTHORIZATION FOR TREATMENT OF A MINOR

I, _____, authorize individuals listed below to bring my child(ren) to his/her dental appointments and grant them access to my child's dental and account records within this office:

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

Name: _____ Relationship to Child: _____

I also understand that:

- *Only the adults listed on this form will be permitted to bring my child to his/her appointment. If the child is brought by anyone other than the individuals on this list,* ***the appointment will be rescheduled****.*
- *Anyone accompanying my child to their appointment must bring a photo ID.*
- *Whoever brings the child to the appointment will be required to complete the necessary paperwork for that day's visit, including medical history forms, consents for planned treatment, and treatment estimates.*
- *Regardless of who brings the child to the appointment, I will be responsible for the financial payments due on my child's account.*
- *It is my responsibility to make changes to this form as-needed. I will notify the Children's Dental Centre of Irving staff if changes need to be made.*

This authorization applies to the following children:

Name of Child: _____ DOB:_____ Name of Child: _____ DOB:_____

Name of Child: _____ DOB:_____ Name of Child: _____ DOB:_____

Authorized adults MUST be listed on this page – parents/relatives listed on the first page of this packet are not automatically included.

Please review and initial:

_____ **MEDICAL RELEASE:** I give permission to my pediatrician or health provider to provide health care information regarding my child(ren) listed above to the dentists and staff at Children's Dental Centre of Irving.

_____ **WEB RELEASE:** I give permission for the use of my child(ren)'s first name and picture for in-office promotions, our website, and for advertising purposes (e.g. our prize winners).

_____ **ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES:** I was provided a copy of this office's Notice of Privacy Practices. I understand I can receive a written copy at my request. **Parent's Initials:**

_____ **NO PHOTOGRAPHY/VIDEO POLICY:** I understand that due to HIPAA and liability compliance issues, **any form of photography or video is not permitted beyond the front reception area of this office**.

_____ **FOR CHILDREN 16 AND OVER (IF APPLICABLE):** I hereby authorize my child (ages 16 and above) to receive dental treatment (e.g. dental checkup, emergency visits, x-rays, cleaning, fluoride) without and authorized person accompanying him/her**.**

Parent's Printed Name: _____ Signature: _____Date: _____

OFFICE AND FINANCIAL POLICIES

Welcome to our practice! To better serve you we have prepared our office policies so that you may have an understanding of how our practice functions. If you have any questions, please feel free to ask.

Please initial each line below:

_____ ***Appointment Times and Cancellations***: Please understand that when we schedule your appointment, we are reserving time for your specific needs; we do not "double book" our appointments, as many offices do. When your appointment is made, a room is reserved, your records are prepared, and our staff is on standby in preparation for your visit. Not showing up to an appointment prevents us from helping other patients in need. For this reason we request that you provide **2 business days notice** if you are not able to keep your scheduled appointment. Missed appointments (including appointments missed due to excessive tardiness) and appointments canceled/rescheduled with less than 2 business day's notice will be charged a **$25 broken appointment fee** (per patient). Our office utilizes appointment reminders via email, text message, automated calls, and personal calls beginning 1 month prior to your appointment. Please make sure we always have your most current contact information on file. No-showing or canceling outside of the appropriate time period for a surgical appointment may result in dismissal from the practice.

_____ ***Parent Presence***: We welcome you to join us in creating a positive experience for your child. Building confidence is our highest goal! If you choose to accompany your child when he/she is called from the waiting area, please allow us to help you help your child grow in our office with helpful phrases and models to explain your visit in child-friendly terms. If you choose to stay in the waiting area, please **do not leave the waiting area during your child's appointment.** Your child will be supervised at all times by a member of our staff. We want their visit to be remembered as a FUN time!

_____ ***Politeness Policy***: Every member of our staff is dedicated to ensuring the best experience for your child and providing quality service to you. We ask that you please show our provider's and staff the same respect and courtesy that is shown to every guest of our office. Abusive language and/or behavior in any form, in office or over the phone, will not be tolerated and will result in dismissal from the practice.

_____ ***Insurance:*** We participate in most insurance plans, but we often **do not know the specific details of your insurance policy. Knowing your insurance benefits is your responsibility.** Please realize that the contract is between you, (the insured), and the insurance company. The amount of coverage you will receive will depend on the quality of the plan purchased by your employer, not the fees of the doctor. Also understand that as a dental care provider, our relationship is with you, not with the insurance company. If you are not insured by a plan with which we do business, or you are uninsured, payment will be expected in full at each visit. If you have insurance, we will submit your dental claim as a courtesy. By signing this form, you authorize your insurance to issue payment to our office. Please note that the balance of your claim is your responsibility whether or not your insurance issues payment. Occasionally your insurance may need you to supply additional information directly to them. Please note that sometimes not all the services required for your needs may be covered by your insurance. **If your insurance changes, it is your responsibility to notify us. Please contact your insurance if you have questions about your coverage.**

_____ ***Copayments and Deductibles:*** **All copayments and deductibles must be paid at the time of service.** This arrangement is part of your contract with your insurance company. Failure on our part to collect copayments and deductibles is considered fraud.

_____ ***Identification and Proof of Insurance:*** We must obtain a photo ID (ex: driver's license) and current proof of insurance (if you are insured). **All patients must complete our patient information and consent for treatment forms to avoid insurance fraud.**

_____ ***Non-Payment:*** If you have a balance due on your account, we will notify you by mail, email, and/or at your next office visit. **Balances are expected to be paid in full unless otherwise discussed with the financial coordinator. The physician does not discuss payments or balances with their patients as they concentrate on your health care.** Please call our office if you receive a statement for a balance that is in question. Any balance left unpaid for over 90 days may be submitted to a collection agency and will be assessed a collection fee of $65.00 plus any other costs/fees incurred while attempting to collect the debt.

_____ ***Insufficient Funds:*** There will be a $30.00 service charge for all insufficient checks that are returned.

_____ ***Office policies*** may change without notice. Current Office Policies are always displayed in our office and available on our website: www.irvingchildrensdental.com

I acknowledge that I understand and accept the above office policies of Children's Dental Centre of Irving.

Parent Printed Name: _____ Signature: _____ Date: _____

Regarding Insurance Verification

When you provide your dental insurance information to us, we will verify that your coverage is active and request a general breakdown of benefits. As a courtesy, in most cases, we will accept assignment of benefits and file claims on your behalf. We will not accept assignment of benefits for DMOs or plans that pay the insured directly.

Upon request, we will provide you with a copy of the breakdown that your insurance sends to us. However, if you have any questions regarding the specifics of your coverage, network status, frequencies or benefits, we insist that you contact your insurance company directly. Please understand that the verification we receive is not binding. Several factors can affect what insurance actually pays, such as having the same service done in more than one office, pending claims that have not yet been applied to your benefits, downgraded procedures, insurance providing incorrect or incomplete information, etc.

Please keep in mind that an insurance plan is a contract between the policyholder and the insurance company. Therefore, it is your responsibility to understand the details of your plan. The treatment plans we provide are estimates only. Ultimately, the parent/guardian of the patient is responsible for any balance left unpaid by insurance.

Our main focus is to provide quality dental care for all of our patients. The doctor's recommendations are based on the best interest of your child's oral and overall well-being and will not be dictated by insurance coverage limitations.

_____
Printed Name

_____
Signature

_____
Date