PEDIATRIC DENTISTRY OF TEXARKANA
Dr. Mitchell Glass • Dr. Brittany Bunch

Patient Registration

Today's Date: _____

Arrival Time: _____

Your Name: _____ Relationship to Patient(s): _____

Patient Information

First Name: _____ Middle Name: _____ Last Name: _____

Preferred Name/Nickname: _____ Gender: _____Female _____Male

Date of Birth: _____ Social Security Number: _____

Parent/Guardian Information

Relationship to Patient(s): _____

First Name: _____ Last Name: _____ Date of Birth: _____

Social Security #: _____ Driver's License #: _____ state: _____

Address: _____ City, State, Zip _____

Cell Phone: _____ Home Phone: _____ Work Phone: _____

Email: _____

I would like to receive email/text reminders for appointments: _____YES _____NO

Primary Insured Information

First Name: _____ Last Name: _____ Date of Birth: _____

Social Security #: _____ Relationship to Patient(s): _____

Employer: _____ Insurance Company: _____

Member ID: _____ Group ID: _____

Secondary Insured Information

First Name: _____ Last Name: _____ Date of Birth: _____

Social Security #: _____ Relationship to Patient(s): _____

Employer: _____ Insurance Company: _____

Member ID: _____ Group ID: _____

Referred by Doctor: _____ Referred by Friend: _____

If not referred, how did you hear about us? (Circle)

Facebook • Tooth Fairy • Google • Outdoor Banners • Phonebook • ALT Magazine • Texarkana Parent Magazine • Sibling Community Event _____ **• Other** _____

Please fill out the front and back of this form completely →

Patient Name: _____ **Birth Date:** _____ **Today's Date:** _____

Health problems that your child may have or medication that your child may be taking could have an important interrelationship with the dentistry your child may receive. Please answer the following questions.

Is your child under a physician's care now? Yes No **If yes, please explain:** _____

Who is your child's physician? _____

Has your child ever been hospitalized or had an operation? Yes No **If yes, please explain:** _____

Has your child ever had a serious head or neck injury? Yes No **If yes, please explain:** _____

Is your child taking any medications, pills, or drugs? Yes No **If yes, please explain:** _____

Is your child on a special diet? _____ Yes No **If yes, please explain:** _____

Is your child allergic to any of the following? _____

Aspirin Penicillin Codeine Acrylic Metal Latex Local Anesthetics

Please list all known allergies: _____

_____

Does your child have, or has your child had, any of the following?

ADD/ADHD	Yes No	Convulsions	Yes No	Heart Trouble/Disease	Yes No	Recent Weight Loss	Yes No
AIDS/HIV	Yes No	Cortisone Medicine	Yes No	Hemophilia	Yes No	Renal Dialysis	Yes No
Alzheimer's Disease	Yes No	Diabetes	Yes No	Hepatitis A	Yes No	Rheumatic Fever	Yes No
Anaphylaxis	Yes No	Drug Addiction	Yes No	Hepatitis B or C	Yes No	Rheumatism	Yes No
Anemia	Yes No	Easily Winded	Yes No	Herpes	Yes No	Scarlet Fever	Yes No
Angina	Yes No	Emphysema	Yes No	High Blood Pressure	Yes No	Shingles	Yes No
Arthritis/Gout	Yes No	Epilepsy/Seizures	Yes No	Hives or Rash	Yes No	Sickle Cell Disease	Yes No
Artificial Heart Valve	Yes No	Excessive Bleeding	Yes No	Hypoglycemia	Yes No	Sinus Trouble	Yes No
Artificial Joint	Yes No	Excessive Thirst	Yes No	Irregular Heartbeat	Yes No	Spina Bifida	Yes No
Asthma	Yes No	Fainting Spell/Dizziness	Yes No	Kidney Problems	Yes No	Stomach Disease	Yes No
Blood Disease	Yes No	Frequent Cough	Yes No	Leukemia	Yes No	Stroke	Yes No
Blood Transfusion	Yes No	Frequent Diarrhea	Yes No	Liver Disease	Yes No	Swelling of Limbs	Yes No
Breathing Problems	Yes No	Frequent Headaches	Yes No	Low Blood Pressure	Yes No	Thyroid Disease	Yes No
Bruise Easily	Yes No	Genital Herpes	Yes No	Lung Disease	Yes No	Tonsillitis/Removed	Yes No
Cancer	Yes No	Glaucoma	Yes No	Mitral Valve Prolapse	Yes No	Tuberculosis	Yes No
Chemotherapy	Yes No	Hay Fever	Yes No	Pain in Jaw Joints	Yes No	Tumors or Growths	Yes No
Chest Pains	Yes No	Heart Attack/Failure	Yes No	Parathyroid Disease	Yes No	Ulcers	Yes No
Cold Sores/Fever Blisters	Yes No	Heart Murmur	Yes No	Psychiatric Care	Yes No	Venereal Disease	Yes No
Congenital Heart Disorder	Yes No	Heart Pace Maker	Yes No	Radiation Treatment	Yes No	Yellow Jaundice	Yes No

Has your child ever had a serious illness not listed above? Yes No **If yes, please explain:** _____

_____

_____

Comments: _____

_____

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 the patient's health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PARENT OR GUARDIAN: _____ **DATE:** _____

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Transfer of Consent for Dental Treatment

Patient's Name:_____ Patient's Date of Birth:_____

Patient's Name:_____ Patient's Date of Birth:_____

Patient's Name:_____ Patient's Date of Birth:_____

Patient's Name:_____ Patient's Date of Birth:_____

Patient's Name:_____ Patient's Date of Birth:_____

A parent or legal guardian must accompany a child younger than 18 years of age to all dental appointments and consent for all treatment provided by Pediatric Dentistry of Texarkana OR designate another adult to accompany the patient(s) and consent for their treatment.

I authorize the following caregiver(s) to accompany and consent for treatment for my child(ren) listed above, which may be required in my absence.

Caregiver's Name:_____ Date of Birth:_____ Relationship to child:_____

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Caregiver's Name:_____ Date of Birth:_____ Relationship to child:_____

I understand that I am still financially responsible for any services provided to my child(ren) that were approved by the authorized caregiver(s).

This authorization will remain in effect until the practice is notified of the designated caretaker's change in status. I understand it is my responsibility as parent or legal guardian to inform this practice of any changes to this authorization.

_____
Today's Date

_____ _____ _____
Parent/Legal Guardian (print) Signature Relationship to Patient

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical 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.

YOUR RIGHTS

When it comes to your medical information, you have certain rights.

Get an electronic or paper copy of your medical record

- You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you.
- We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.

Ask us to correct your medical record

- You can ask us to correct health information about you that you think is incorrect or incomplete.
- We may say “no” to your request, but we’ll tell you why in writing within 60 days.

Request confidential communications

- You can ask us to contact you in a specific way or to send mail to a different address.
- We will say “yes” to all reasonable requests.

Ask us to limit what we share

- You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say “no” if it would affect your care.
- If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say “yes” unless a law requires us to share that information.

Get a list of those with whom we’ve shared information

- You can ask for a list of the times we’ve shared your health information for six years prior to the date you ask, who we shared it with, and why.
- We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures. We’ll provide one accounting a year for free, but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

Get a copy of this privacy notice

- You can ask for a paper copy of this notice at any time.

Choose someone to act for you

- If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information.

File a complaint if you feel your rights are violated

- You can complain if you feel we have violated your rights by contacting us using the information at the bottom of page 2.
- You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.
- We will not retaliate against you for filing a complaint.

YOUR CHOICES

For certain health information, you can tell us your choices about what we share.

You have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation

- Include your information in a hospital directory

In these cases we never share your information unless you give us written permission:

- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes

In the case of fundraising:

- We may contact you for fundraising efforts, but you can tell us not to contact you again.

OTHER USES AND DISCLOSURES

We typically use or share your health information in the following ways.

Treat you

- We can use your health information and share it with other professionals who are treating you.

Run our organization

- We can use and share your health information to run our practice, improve your care, and contact you when necessary.

Bill for your services

- We can use and share your health information to bill and get payment from health plans or other entities.

We can also share information about you in other ways such as:

- Help with public health and safety issues
  - Preventing disease
  - Helping with product recalls
  - Reporting adverse reactions to medications
  - Reporting suspected abuse, neglect, or domestic violence
  - Preventing or reducing a serious threat to anyone's health or safety
- For health research
- Comply with the law
  - We will share information about you if state of federal laws require it, including the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
- Respond to organ and tissue donation requests
- In response to lawsuits or legal actions, court or administrative order, or to a subpoena
- Address workers' compensation, law enforcement, and other government requests
  - Workers' compensation claims
  - Law enforcement purposes or with a law enforcement official
  - Health oversight agencies for activities authorized by law
  - Special government functions such as military, national security, and presidential protective services
- Work with a medical examiner or funeral director
  - We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

OUR RESPONSIBILITIES

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html

CHANGES TO THE TERMS OF THIS NOTICE

We can change the terms of this notice and the changes will apply to all information we have about you. The new notice will be available upon request in our office and on our web site.

I, as legally responsible parent/guardian, have read and understand this notice:

Child's Name (print)	Parent/Legal Guardian Signature	Date

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Office Policies

Confirmations

We will attempt to contact you either by phone, text or email prior to your scheduled appointment. Please make sure we have your correct contact information on file. **All appointments must be confirmed**. If you do not confirm, your appointment time may be filled and we will have to reschedule your appointment. We understand life is busy with kids and appointments can easily be forgotten; therefore, we do send quite a few text reminders. You may opt out of the text reminders at any time.

Late Arrivals

Please arrive a few minutes prior to your appointment time to fill out any necessary paperwork and update your child's medical history. If you arrive more than 10 minutes late, your appointment may have to be rescheduled.

Broken Appointments

Valuable time has been reserved for your child's dental appointment. A missed appointment results in lost time, which could be offered to another patient in need of treatment if the proper cancellation notice is given. We respectfully ask patients to be prompt and keep their appointments. **A 24-hour notice is required to cancel or change an appointment.** A $75.00 fee may be charged to your account if the appointment is missed, cancelled or rescheduled without 24-hour notice. **Patients with two or more broken appointments will not be rescheduled.**

Patient Care

A Parent or Legal Guardian must be present with patients for all appointments. **If a parent/legal guardian is not available, prior authorization is required. One parent/guardian may accompany the patient to the treatment area.**

We strive to see all patients on time; however, there are times when our schedule is delayed in order to accommodate an emergency or to give special care to a child. Please accept our apology in advance if this occurs during your appointment. Be assured that we will give your child extra time and attention as well if s/he is ever in need.

Financial

Parents/Guardians are responsible for payment of services or any deductibles, co-payments or balances not covered by insurance. Our office bases treatment on your child's needs, not what your insurance will pay. We can provide an estimate of the treatment cost, but we will not know the exact payment until after the claim is submitted. If your insurance pays more than estimated, it will be credited to your account. If it pays less than expected or if services are not covered, the parent/guardian is responsible for the balance within 45 days of the service. Benefit payments will be paid directly from your insurance company to Dr. Mitchell Glass. All returned checks will result in a $50 charge.

Signature:_____ Date:_____