PEDIATRIC DENTISTRY OF TEXARKANA

Dr. Mitchell Glass • Dr. Brittany Bunch

Patient Registration

Today's Date: _____ Your Name: _____ Relationship to Patient(s): _____

Patient Information

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

Nickname: _____ Date of Birth: _____ ☐ Female ☐ Male

Parent/Guardian #1 Information

Relationship to Patient(s): _____

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

Address: _____ City, State, Zip _____

Cell Phone: _____ Email: _____

Parent/Guardian #2 Information

Relationship to Patient(s): _____

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

Address: _____ City, State, Zip _____

Cell Phone: _____ Email: _____

Child lives with: ☐ Both parents ☐ Mother ☐ Father ☐ Other _____

Primary Insured Information

Relationship to Patient(s): _____ First Name: _____ Last Name: _____

Date of Birth: _____ Social Security #: _____

Employer: _____ Insurance Company: _____

Member ID: _____ Group ID: _____

Secondary Insured Information

Relationship to Patient(s): _____ First Name: _____ Last Name: _____

Date of Birth: _____ Social Security #: _____

Employer: _____ Insurance Company: _____

Member ID: _____ Group ID: _____

How did you hear about us?

Referred by Doctor: _____ ☐ Google ☐ Facebook ☐ Tooth Fairy ☐ Other _____

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

Health History

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:

Who is your child's physician? _____

Is your child under a physician's care now? ☐ YES ☐ NO If yes, please explain:_____

Is your child taking any medications? **(prescribed & over-the-counter)** ☐ YES ☐ NO If yes, please list: _____

_____

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:_____

Does your child have congenital heart disease? ☐ YES ☐ NO **If YES, is SBE prophylaxis required?** ☐ YES ☐ NO

Is your child allergic to any of the following:

☐Aspirin ☐Penicillin ☐Codeine ☐Acrylic ☐Metal ☐Latex ☐Local Anesthetics

Please list any other know allergies: _____

Has your child ever had any history with the following:

☐ ADD/ADHD
☐ AIDS/HIV
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Anxiety
☐ Arrhythmia
☐ Artificial Bones/Joints
☐ Artificial Heart Valve
☐ Asthma/Breathing Problems
☐ Autism
☐ Behavior/Emotional Disorder
☐ Blood Disorder/Hemophilia
☐ Blood Transfusion
☐ Brain Injury
☐ Bladder Problems
☐ Bone/Joint Problems
☐ Cancer
☐ Cerebral Palsy
☐ Cleft Lip/Palate
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Disease
☐ Cortizone Medicine
☐ Crohn's Disease
☐ Cystic Fibrosis
☐ Developmental Delays
☐ Diabetes
☐ Down Syndrome
☐ Ear/Hearing Problems
☐ Eczema
☐ Epilepsy/Seizures
☐ Excessive Bleeding
☐ Excessive Gagging
☐ Eye/Vision Problems
☐ Fainting
☐ GERD
☐ Heart Problems
☐ Herpes
☐ High/Low Blood Pressure
☐ Hypoglycemia
☐ Jaundice
☐ Jaw Problems/TMJ/TMD
☐ Kidney Problems
☐ Liver Problems/Hepatitis
☐ Malignant Hyperthermia
☐ Metabolic Disorder
☐ Milk Sensitivity
☐ Pacemaker
☐ Psychiatric Care
☐ Rheumatic Fever
☐ Scarlet Fever
☐ Sensory Processing Disorder
☐ Sickle Cell
☐ Sleep Apnea
☐ Speech Problems
☐ Spina Bifida
☐ Thyroid Disease
☐ Tonsillectomy
☐ Tuberculosis

If your child has any other significant medical history not listed above, please describe:

_____

_____

To the best of my knowledge this medical form has been accurately completed. I understand that providing incorrect or omitting information can be dangerous to the patient's health. As legal guardian, it is my responsibility to inform the dental office of any changes in medical status.

Signature of Parent/Legal Guardian: _____ **Date:** _____

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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

PEDIATRIC DENTISTRY OF TEXARKANA

Office Policies

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

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 by 2:00 pm the day prior, your appointment time will be rescheduled. 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/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.

Signature:_____ **Date:**_____

→ **Please turn over and complete the back of this form as well** →

Financial Policy

Pediatric Dentistry of Texarkana is committed to providing the best dental care for our patients and our fees are usual and customary for our area. Parents/guardians are responsible for payment of services or any deductibles, co-payments or balances not covered by insurance at the time of treatment.

Our office bases treatment on your child's needs. We can provide an estimate of the treatment cost, but we will not know the exact cost until after treatment is completed.

Responsibility for payment of divorced or separated parents/guardians rests with the parent who brings the child in for treatment. Any court ordered judgement is between the parents/guardians involved, not the dental office.

Payment is due at the time services are rendered. We accept cash, most debit/credit cards, CareCredit, and checks $250 and under. All returned checks will result in a $30 charge.

Dental Insurance

We accept dental insurance, but are only "in-network" with certain insurance companies.

- We will gladly file a claim on the patient's behalf, but must have current and accurate insurance and employer/employee information on file.
- Dental Plan benefits are determined by you or your employer, not the dentist office.
- The dental insurance policy is a contract between you and your insurance company and reimbursement levels are dependent upon the premiums you pay and the benefit you/your employer selects.
- It is the parent's/guardian's responsibility to be aware of the contract benefit of his/her insurance policy and any copayment or deductible obligation.
- We will provide an insurance estimate; however, it is not a guarantee that your insurance will pay exactly as estimated. Insurance coverage is subject to limitations, exclusions, waiting periods, frequency, age restrictions, deductibles, and maximums, etc. We will not know the exact balance until after treatment is completed and the insurance claim is submitted and paid out.
- If the insurance pays more than estimated, it will be credited to the patient account.
- If insurance payment is not received within 45 days, the parent/guardian is responsible for the total balance at that time.
- If there is a balance after insurance pays out, payment must be received within 45 days.
- If the insurance payment is less than expected, the parent/guardian is responsible for the total balance at that time.

Signature:_____ **Date:**_____

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903.831.1000 WWW.PDTXAR.COM

Consent to be Treated at Pediatric Dentistry of Texarkana

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

I, as legally responsible parent/guardian of the patient listed above, give my consent for Pediatric Dentistry of Texarkana to provide dental treatment for my child for this appointment and future appointments.

I understand that though good results are expected, potential complications may occur in dentistry. The possibility and nature of complications cannot be accurately anticipated; therefore, there can be no absolute guarantee as to the outcome or long-term prognosis of treatment.

I will inform the doctor of my child's complete medical history including any recent surgeries, all medications, changes in medical history, and present mental and physical condition.

I, as legally responsible parent/guardian of the patient listed above, give my consent for dental treatment.

_____
Today's Date

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

PEDIATRIC DENTISTRY OF TEXARKANA

Transfer of Consent for Dental Treatment

A parent/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. If you wish to give consent to another adult, please complete below.

Patient's Name:_____ Date of Birth:_____

Patient's Name:_____ Date of Birth:_____

Patient's Name:_____ Date of Birth:_____

Patient's Name:_____ Date of Birth:_____

Patient's Name:_____ Date of Birth:_____

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:_____

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

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

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**