Sea of Smiles
PEDIATRIC DENTISTRY

Patient Information

Patient Name:_____ Date:_____
Last First MI

Preferred Name: _____ DOB: _____ Age: _____ ☐Male ☐Female

Home Address: _____ City: _____ State: _____ Zip: _____

Sibling Name(s):_____

Pets/Hobbies:_____

Please circle the phone number and e-mail that is the best to confirm appointments.

Father's Information

☐Guardian ☐Step

Name:_____

DOB: _____

Employer:_____

Home Phone #:_____

Cell Phone #:_____

E-mail: _____

Mother's Information

☐Guardian ☐Step

Name:_____

DOB: _____

Employer:_____

Home Phone #:_____

Cell Phone #:_____

E-mail: _____

In case of an emergency, please call:

Name:_____ Phone #:_____

Referral Information

Whom may we thank for referring you to our practice?

☐ Another Patient _____ ☐ School _____

☐Dental Office _____ ☐ Pediatrician _____

☐ Google ☐Facebook

☐ DFW Child Magazine ☐ Yelp

☐ Other _____

Medical History

Has your child ever been diagnosed as having any of the following conditions? Please check yes or no:

	Yes	No		Yes	No		Yes	No
ADD/ADHD	☐	☐	Diabetes	☐	☐	Mental Disabilities	☐	☐
AIDS/ HIV+	☐	☐	Down Syndrome	☐	☐	Physical Disabilities	☐	☐
Allergies/Sinus	☐	☐	Eye Problems	☐	☐	Pregnant	☐	☐
Asthma	☐	☐	Hearing Loss	☐	☐	Psychiatric Problems	☐	☐
Autism	☐	☐	Heart Murmur	☐	☐	Rheumatic Fever	☐	☐
Cancer	☐	☐	Heart Problems	☐	☐	Sensory Disorder	☐	☐
Cerebral Palsy	☐	☐	Hemophilia	☐	☐	Shunts	☐	☐
Convulsions/Seizures	☐	☐	Hepatitis/Type_____	☐	☐	Tuberculosis	☐	☐
Spina Bifida	☐	☐	Other _____					

	Yes	No
1. Was your child full term?	☐	☐
2. Did your child have any difficulty after birth or any serious illnesses the first year of life?	☐	☐
3. Is your child being treated by a physician at this time? If yes, why?_____	☐	☐
4. Is your child taking any medication/vitamins at this time? If yes, what?_____	☐	☐
5. Has your child ever been hospitalized? If yes, explain._____	☐	☐
6. Is your child allergic to anything? (medicine/food) If yes, what?_____	☐	☐

7. Does your child have problems in: ☐ concentrating ☐ learning ☐ cooperating ☐ understanding

8. Name of child's physician:_____ Physician's phone #:_____

Date of last visit:_____ Immunizations up to date? ☐ Yes ☐ No

9. How would you rate your child's attitude toward medical / dental visits?
☐ positive ☐ anxious ☐ negative

10. Is there anything else we should know about your child?_____

_____

Staff comments: _____

_____

Dental History

1. Is this your child's first dental visit? ☐Yes ☐No
   If no, give date of last examination:_____ Dentist name:_____

2. Has your child ever had any of the following? Please check.
☐ abscesses ☐ toothaches ☐ cold sores ☐ ulcers
☐ bad breath ☐ injury to front teeth ☐ grinding

3. Does your child have any habits or a history of a habit?
   Pacifier ☐ Yes ☐ No Age discontinued _____

   Finger / thumb ☐ Yes ☐ No Age discontinued _____

4. Is there a history of dental decay or missing teeth in the family?
   ☐Yes ☐No If yes, Explain:_____

5. Are your child's teeth brushed once or more a day by an adult? ☐Yes ☐No ; Floss? ☐Yes ☐No

6. What dental concerns do you have about your child?_____

_____

7. If your child is under the age of 6, when did first baby tooth erupt?_____

Diet History

1. Did or Do you breast feed your child? ☐Yes ☐No
   What age did you discontinue breastfeeding?_____

2. Did or Do you bottle feed your child? ☐ Yes ☐ No
   What age did you discontinue bottle-feeding?_____

3. What foods does your child like for a snack?_____

4. What does your child drink daily? _____

I understand that the information that I have given is correct to the best of my knowledge and it is my responsibility to inform this office of any changes in my child's medical status. I authorize Sea of Smiles Pediatric Dentistry to take x-rays, models, photographs, and other diagnostic aids deemed appropriate to make a thorough diagnosis of my child's dental needs. I give Dr. Doan and her staff permission to send records or x-rays to another facility/doctor in case of emergency. This consent shall remain in full force and effect until canceled by either party.

_____ _____ _____

Signature of parent or guardian Relationship to patient Date

Sea of Smiles Pediatric Dentistry

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been informed by your office of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the rights to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address below to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name

Relationship to Patient

Signature

Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our *Notice of Privacy Practices*, but acknowledgement could not be obtained because:

- □ Individual refused to sign
- □ Communication barriers prohibited obtaining the acknowledgement
- □ An emergency situation prevented us from obtaining acknowledgement
- □ Other (Please Specify):

Sea of Smiles Pediatric Dentistry
Financial Arrangements and Insurance Policy

We are committed to providing your child with the highest standard of dental care. We welcome your child and family into our practice and we will strive to make your child's dental experience positive and pleasant. In order to achieve these goals, and focus on caring for your child, we need your assistance and understanding of our financial policy.

Payment of services is due in full at the time services are rendered. We accept cash, personal check, cashier's check, money order, care credit, Visa, MasterCard, Discover, and American Express. This includes all new patient evaluation appointments, prophylaxis (professional cleanings), emergency evaluations, recare appointments and **TREATMENT** sum $200.00 or LESS**. Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services regardless of dental insurance.** As a courtesy, if you have dental insurance and paid in full we will submit your claim for you by hand or electronically if your plan allows and have reimbursement from your insurance carrier be sent directly to you. It is your responsibility to provide accurate insurance information so that this can be done in a timely manner.

For TREATMENT over $200.00….

If you do not have dental insurance, payment is due in full on the date of services are rendered. If you have any other out-of-network insurance, we will verify your policy; however, insurance companies do not always release specific information regarding coverage. Please understand that all insurance policies are different and contain various provisions and limitations. **We have absolutely no control over the reimbursement process or determination of eligibility.** At your child's evaluation appointment, we will attempt to estimate your dental benefits to the best of our ability, this is an **ESTIMATE ONLY**, not a guarantee of coverage and should not be depended on as the final decision. The patient will pay their **ESTIMATED** share at the time of treatment. The fee estimated for dental treatment can only be extended for a period of **90 days** from the date of the patients last examination. At the treatment appointment we will collect your estimated portion and send a claim to insurance for their estimated portion. Should questions arise, it is best to contact your insurance company directly. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company directly. However, this dental office cannot render services on the assumption that our charges will be paid by an insurance company. Insurance companies have a wide variety of rules, plan limitations and exclusions that our offices may not be aware of. Dental insurance is a benefit for the patient provided by their employer and the contract lies between the patient, employer and the insurance company, not the dentist. If you have insurance and it is, Blue Cross Blue Shield or Delta Dental, payment is still due in full on the date services are rendered due to some of their plan limitations on payment to the out-of-network provider.

Balances

Once insurance has paid their share, a statement will be sent to the patient for the remaining balance and will be due to our office **upon receipt**. Any under payment made by your insurance company is your responsibility. You will receive a statement reflecting the balance, and we ask that you pay your remaining portion upon receipt of statement. **If we have not received payment from your insurance company within 45 days of the services being rendered, you will be responsible for the balance.** Any account that is overpaid by your insurance will receive a prompt fund. **Our office reserves the right to stop filing your insurances at any time if there is a problem with your account because of your insurance carrier, or your unwillingness to cooperate**. As a courtesy to you, our staff will assist you with any conflicts you may have regarding your insurance, but cannot guarantee the outcome. **Any account balance over 90 days will be turned over to out attorney for legal action. Returned personal checks are subjected to transaction fee by our office.**

Cancelled Appointments

We reserve the right to charge $50.00 for appointments cancelled or broken without 48 hours advanced notice.

I understand that the fee estimate that was provided to me for dental care can only be extended for a period of 90 days from date of the patient examination.

I grant permission to you or your assignee, to telephone me at home or at work to discuss matters related to this form.

If my child needs dental treatment, I authorized dental benefits to be paid directly to Sea of Smiles Pediatric Dentistry since I am only paying my estimated portion at the time service is rendered.

I have read the above conditions of treatment and payment and agree to their content.

Patient Name: _____

Parent or Guardian Signature: _____ Date: _____

Sea of Smiles
PEDIATRIC DENTISTRY

RELEASE FOR MINOR CHILDREN (Under 18)

I, _____, parent or official guardian of

_____hereby grant permission to Sea of Smiles Pediatric Dentistry representatives, to take and use: photographs and/or digital images of my child for use as follows: printed publications or materials, electronic publications, or Web sites. I agree that my child's name (not last name) and identity may be revealed in descriptive text or commentary in connection with the image(s). I authorize the use of these images without compensation to me.

_____ (Date)

_____ (Signature of Parent or Guardian)