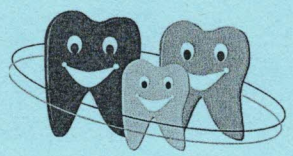
Fadal Pediatric Dentistry
5 Doctor Circle
Longview, Texas 75605
Tel 903.21BRUSH Fax 903.544.6046



Date: _____

Patient Information

Child's First Name: _____ Middle Initial: ____ Last Name: _____

Date of Birth: _____ Name Your Child Goes By: _____ Gender: **M** or **F**

Address: _____ City: _____ State:_____ Zip Code: _____

Home Phone: _____ Cell Phone: _____ Alternate Phone: _____

Email Address: _____

◯ I would like to receive correspondences via e-mail ◯ I would like to receive correspondences via text message

Whom may we thank for referring you to our office? _____

Responsible Party

Who Is Primarily Responsible for the Child? ◯ Mother ◯ Father ◯ Legal Guardian ◯ Other: _____

Mother **OR** Legal Guardian First Name: _____ Middle Initial: ____ Last Name: _____

Date of Birth: _____ Marital Status: ◯Married ◯ Single ◯ Widowed ◯ Divorced ◯ Separated

Employer: _____ Work Phone Number: _____

Social Security Number: _____ Primary Phone Number: _____

Mother OR Legal Guardian DL #:_____ Father DL #: _____

Father First Name: _____ Middle Initial: ____ Last Name: _____

Date of Birth: _____ Marital Status: ◯Married ◯ Single ◯ Widowed ◯ Divorced ◯ Separated

Employer: _____ Work Phone Number: _____

Social Security Number: _____ Primary Phone Number: _____

Who is accompanying the child today? _____

EMERGENCY CONTACT: _____ Relationship to Child: _____ Phone #:_____

Insurance Information

Is Patient Covered by Medicaid or CHIP? ◯ YES ◯ NO Member ID#: _____

Is the Child covered by Private Dental Insurance? ◯ YES ◯ NO Name of Dental Insurance: _____

Name of the Policy Holder: _____ Policy Holder D.O.B: _____

Policy Holder Social Security Number: _____ Employer: _____

Medical and Dental History

Name of Child's Pediatrician/ Physician: _____

Name of Child's Cardiologist or Specialist: _____

Is your child currently taking any medications? ◯ YES ◯ NO If **YES**, please list below:

Medication: _____ Reason Taken: _____

Medication: _____ Reason Taken: _____

Medication: _____ Reason Taken: _____

Is your child allergic to any medications: ◯ YES ◯ NO If **YES**, please list below:

_____ _____

_____ _____

Is your child allergic to **LATEX**? ◯ YES and ◯ NO

TEENS ONLY: Is patient using tobacco products? ◯ YES ◯ NO

FEMALES ONLY: Is patient taking birth control ◯ YES ◯ NO

Is there any possibility that the patient is **PREGNANT**? ◯ YES ◯ NO

Any previous surgeries? _____

Does your child get anxious or apprehensive when visiting the dentist? ◯ YES ◯ NO If **YES**, please explain what bothers your child most about the visit: _____

_____

Please check if your child has ever been diagnosed or treated for any of the following:

- ◯ Asthma
- ◯ ADHD/ ADD
- ◯ Autism
- ◯ Anemia/ Bleeding Disorder
- ◯ Epilepsy/ Seizures
- ◯ Seasonal Allergies
- ◯ Mental Delays
- ◯ Personality Disorder
- ◯ Neurological Disorder
- ◯ Eating Disorder
- ◯ Acid Reflux/ GERD
- ◯ Speech Impairment
- ◯ Thyroid Disorder
- ◯ Down's syndrome
- ◯ Cerebral Palsy
- ◯ Cleft Lip/ Palate
- ◯ HIV/ AIDS
- ◯ Diabetes
- ◯ Hepatitis (Type ____)
- ◯ Heart Disease
- ◯ Heart Murmur
- ◯ Cancer/ Tumors
- ◯ Liver Disease
- ◯ Kidney Disease
- ◯ Visual Impairment
- ◯ Hearing Impairment
- ◯ Hypertension
- ◯ Rheumatic Fever
- ◯ Tuberculosis

Other_____

Because your child is minor, it becomes necessary that a signed permission is obtained from a parent or guardian before any and or all necessary dental service can be started and accomplished.

The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental services and the use of those methods appropriate there to. This consent shall remain in full force and effect until cancelled by either party. Furthermore, I will be responsible for any bill incurred on this child for dental treatment.

Signed: _____ Relation: _____ Date: _____

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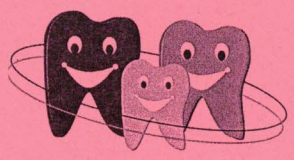

Date:_____

Consent for Treatment

I,_____ give permission for the following individuals (of legal age (18)) to bring _____ in for any dental appointments, cleaning, x-rays or invasive treatment. Also, but not limited to, to give permission to administer local anesthetic and/or conscious sedation. The individual accompanying the child must provide a valid Driver's License for us to put a copy on file.

Name:_____Relationship to Patient:_____

Name:_____Relationship to Patient: _____

Name:_____Relationship to Patient:_____

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

Name: _____Relationship to Patient: _____

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

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 received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. 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 above to obtain a current copy of the *Notice of Private 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.

Patient Name _____

Relationship to Patient: _____

Signature: _____

Date _____

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

Date:	Initials:	Reason:

ITEM 070-5962/25950 © MAY 2002

FINANCIAL POLICY

Our first priority is to provide the best possible dental care for your child.

- We expect payment when services are rendered.
- As a **courtesy** to our patients we will file your dental insurance for you. We **require** that you **pay** any applicable **deductible** and/or the percentage of what your company does not pay. If you have any questions concerning this policy please ask prior to services rendered. No balance is carried in this office over 60 days.
- To all our patients we will provide a **treatment estimate** after the initial exam of any follow up treatment needed. If you do not receive one, please ask. We want our patients to be **prepared** for any **out of pocket expense**.
- The parent or Guardian who brings the child for their initial visit is responsible for payment independent of what a divorce decree may state. Reimbursement must be made between the divorced parties. **We will not intervene.**

PLEASE NOTE: To our patients with **Medicaid**, we require a copy of your **Medicaid Card** on **every** visit, your child **cannot** be seen without it. Please present it on check-in.

We accept: Cash, Check (<u>$35. service charge on all returned checks</u>)
All major **credit cards**
Care Credit Card (please ask for details)

AUTHORIZATION

1. I authorize Fadal Pediatric Dentistry and/or its representatives to release any necessary information to my insurance company.
2. I have read the above financial policy and understand and agree with the terms set forth regarding payment.

_____

Signature of responsible party Date

SCHEDULING GUIDELINES & RESPONSIBLITIES

The Doctors and Staff at our office have put much effort and time into designing our scheduling system to provide your child with excellence in Pediatric Dental Care. In the course of designing our schedule it has become necessary to make our patient's parents responsible for certain aspects of their appointments. We strive to be considerate of our patients when scheduling, we ask that our patients be considerate of our schedule too.

As a courtesy to our patients we provide a confirmation call through the use of an automated phone calling system. At times though, technical reasons may keep this system from confirming appointments. For that reason we **require** that our patients be **responsible for their appointment time**.

We understand that **time** and **unforeseen** occurrence befall all people, but whenever possible we **require** a 24 hour notice to change an appointment.

Missed appointments are **wasted** time where the doctors could have provided care for someone else. Due to the number of patients that we desire to see it has become necessary to implement the following policy.

During a series of appointments, **if the patient misses 2 appointments with out calling in advance, it will be necessary to dismiss the patient from our practice**. And after that time we will only see the patient on an emergency basis for the following 30 days.

We appreciate your cooperation in this area. By signing this form you agree to adhere as closely as possible to our appointment requirements.

Thank you and we look forward to serving your child's dental needs.

Sign Date