Welcome to Dental Care 4 Kids

Patient Information

Last Name _____ First Name _____ Preferred First Name _____

Date of Birth_____ Sex: ☐ Male ☐ Female Primary Language _____ Grade _____

Home Address: _____ _____ Contact Phone #_____

Who is accompanying patient today? Name _____ Relation: _____

In case of emergency, whom should we contact? Name _____Phone# _____

How were you referred to our office? ☐ Website ☐ Print advertising ☐ Other Doctor: Name _____

☐ Friend/Relative _____ ☐ Sibling _____ ☐ Other: _____

Parent/Guardian Information

Father ☐ Stepfather ☐ Guardian ☐

Name: _____ DOB: _____ Driver's Lic # _____

Employer:_____ Home#:_____ Work#: _____

Home Address _____ City _____ Zip code _____

Cell # _____ email for contact: _____@_____

Mother ☐ Stepmother ☐ Guardian ☐

Name: _____ DOB: _____ Driver's Lic # _____

Employer:_____ Home#:_____ Work#: _____

Home Address _____ City _____ Zip code _____

Cell # _____ email for contact: _____@_____

Insurance/Financial Information

Name _____ Relationship _____

Mailing Address _____ Contact phone # _____

Insured's Name _____ Date of Birth _____ Social Security #:_____-_____-_____

Relationship to patient _____ Employer _____ Employer's address _____

Insurance Company Name _____ Ins address _____

Ins Phone # _____ Group # _____ ID # _____

*For our patients with dental insurances, we accept payment for treatment directly from many insurance companies, but we are not contracted with any insurance companies. The guardian/parent/adult with the patient is responsible for payment of any non-covered services at the time the patient is seen. If we do not receive payment from your insurance company within 5 weeks after treatment is completed, the guardian/parent will be expected to pay for all dental services.

Signature of parent/guardian: _____ Date: _____

Dental History

Reason today's visit? ☐ Checkup/cleaning ☐ Dental Caries/Cavities ☐ Mouth injury ☐ Toothache ☐ Oral Habits

Other reason _____

Previous Dentist _____ Last Dental Visit/Reason _____

Any unhappy dental experiences? _____ Anxiety concerns? _____

How do you think your child will behave today? ☐ Happy ☐ Anxious ☐ Timid ☐ Afraid ☐ Resistant

Does your child have any of the following habits?

☐ Thumb/Finger sucking ☐ Snoring/sleep apnea ☐ Nursing/bottle ☐ Teeth grinding ☐ Mouth breathing

Does your child use any fluoride products at home? ___ Toothpaste ___Fluoride rinse ____Prescription toothpaste

Medical History

Patient's Physician _____ Date of last visit _____

Please list any current medical conditions:_____

Please list any medications (prescription and OTC) taking: _____

History of any surgeries? __No __Yes (explain) _____

Hospitalization history? __No __Yes (explain) _____

Are there any Drug/Latex/Metal/Food allergies? If yes, please explain: _____

Any cardiac (heart) or other conditions that may require an antibiotic premedication? __No __Yes (list) _____

Does the patient have any history of any of the following:

__Anemia/Hemophilia	__Cerebral Palsy	__Heart disease	__Premature baby
__Asthma	__Convulsions/Seizures	__Heart Murmur	__Problems with anesthesia
__Autism/ASD	__Developmental Delay	__Hearing Problems	__Prolonged bleeding
__ADD/ ADHD	__Diabetes	__Hepatitis/Liver Issues	__Rheumatic Fever
__AIDS/HIV	__Down Syndrome	__High/Low Blood Pressure	__Seasonal allergies
__Birth Defect	__Ear/Nose Trouble	__Kidney Disease	__Tuberculosis (TB)
__Blood Disorder	__Gastric Reflux	__Lung Disease	__Thyroid Disease
__Cancer	__Handicap/Disability	__Pregnancy	__Sensory Integration Issues
__MTHFR gene mutation	__ Any other medical condition not listed		

Comments/explanations:

_____

_____

Are the patient's recommended immunizations up-to-date? __Yes __No: please explain _____

Acknowledgement of Patient Information/Authorization for Initial Evaluation

The information I have given is correct to the best of my knowledge. I understand that all the information is confidential, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services for my child for an initial evaluation. Any other dental services required will be explained and authorized by a parent/guardian after the initial visit.

Signature _____Name _____ Date _____

NOTICE OF PRIVACY PRACTICES—DENTAL CARE 4 KIDS, Drs. Andrea Gonzales & Tom Wickersham

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect with your signature agreement, and will remain in effect until we replace it. You may request a copy of our Notice at any time.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: we may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time.

Persons Involved in Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) a family member, your personal representative or another person responsible for your care, of your location, general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on the determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your healthcare. We will also use our professional judgment and our experience with common practice to make reasonable inference of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms for health information.

Marketing Health-Related Services: We will not use your health information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorize federal officials health information required to lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, email or letters).

PATIENT RIGHTS

Access: You have access to the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. You must make a request in writing to obtain access to your health information. If you prefer, we will prepare a summary or an explanation of your child's health information for a fee.

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use of disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us. If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information, you may complain to us. You also may submit a written complaint to the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request. We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services. Local Contact: Dr. Andrea Gonzales, Dental Care 4 Kids, (972) 874-2800

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement.
I have received a copy of this office's Notice of Privacy Practices.
Signature of Parent/Guardian _____ 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) _____

Name (please print) _____ Signature _____ Date _____

Financial and Insurance Agreement
Dental Care 4 Kids/ Drs. Andrea Gonzales & Tom Wickersham

We have found that most misunderstandings occur due to misconceptions regarding insurance. It is our goal to focus on your child, the patient, as opposed to spending inordinate amounts of time collecting insurance information or payments. We will make every effort to assist you in filing your claims. We file claims electronically (if your company accepts them) the same day services are provided. The employer that purchased your plan determines the dollar amount of your insurance benefits. We have no control over the coverage. Also, insurance is meant to be a supplementation to help defray costs, but is not designed to pay for all procedures in entirety.

Payment: Payment is expected at the time of service, and we accept cash, checks, MasterCard, Visa and Care Credit approved financing. We will expect the payment of any co-pays, deductibles or other charges, not expected to be covered by insurance, at the time of service (when the patient is seen).

Dental Insurance: We will assist you in filing your insurance claims for you, provided that you have given us the accurate and complete information at least 2 business days prior to your child's appointment and that your insurance company has provided us with all the necessary information. We are **not** contracted with any insurance companies nor are we a member of any PPO networks. We have no control over the reimbursement process or determination of eligibility for any members, and we cannot guarantee any amount of payment by your insurance company. You are responsible for the entire fee for all services provided, regardless of how your insurance administers your coverage. Any balance remaining after we've received insurance payment is your responsibility. If we have not received payment from your insurance company within 45 days of services being rendered, you will be responsible for the entire balance.

For patients with Delta Dental, Blue Cross/Blue Shield (outside the state of Texas), ACA (Obamacare) and individualized plans, we will ask that you pay for the services, in full, at the time of service, and we will submit the claims electronically for you to be reimbursed by your insurance company. For any insurance companies that we are unable to obtain coverage information from, or that pay solely on a fee schedule and will not provide us with the fees, we will ask for payment for services, in full, at the time of service and we will give you an itemized receipt and form for you to submit to your insurance company for reimbursement.

Divorce: In matters of separation or divorce, the parent or guardian accompanying the patient on the day of service is responsible for payment on that day. We cannot intervene in matters of divorce, nor can we contact a parent/guardian not present in our office for payment.

Upon signing this document, you agree to all terms and conditions herein and this agreement will be in full force and effect.

Patient Name:_____

Parent/Guardian/Responsible Party Name(Printed):_____

Parent/Guardian/Responsible Party Signature:_____

Date:_____

Patient(s) Name: _____ Patient(s) DOB:_____

Completed by (name): _____ Relationship to patient_____

Preference Regarding Communications of Health Information for Patients of Dental Care 4 Kids

I wish to be contacted in the following manner(s) regarding the patient's care:

Home Telephone:_____ Work Telephone: _____

( ) OK to leave message with detailed information ( ) OK to leave message with detailed information

( ) Leave message with call back number only ( ) Leave message with call back number only

Cell Telephone:_____ Email address: _____

( ) OK to leave message with detailed information ( ) OK to include detailed information

( ) Leave message with call back number only ( ) Send contact information only

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information by persons not listed on the original family paperwork will require specific authorization prior to the disclosure of any medical information.

Signature of Parent/Legal Guardian: _____ Date: _____

RADIOGRAPH ('X-Ray') POLICY OF DENTAL CARE 4 KIDS

To provide a complete diagnosis, it is imperative that Dr. Gonzales and Dr. Wickersham have all the necessary radiographs (*common term is 'X-rays'*). The following information will provide you with a thorough explanation of the different types of radiographs, the purpose of each and how often each is taken. Please know that radiographs are taken as a necessity. It is impossible to provide a thorough and complete examination without them. Most insurance companies pay for radiographs and some do not. We do not base your child's treatment on your insurance company's allowances. We choose to provide services based on your child's needs.

It is important that you are provided with this information to better understand radiographs and why they are needed. Please read each section and sign the bottom of the form to let us know that you have read and understood our philosophy. If you have any questions concerning this material, please ask our staff.

We utilize the latest technology of digital radiography which greatly reduces radiation exposure.

BITEWING X-RAYS: Includes 2-4 radiographs that show the teeth biting together. This type of radiograph shows any decay that may be present between the teeth. Bitewings are updated once per year, unless your child is at an age where they are losing a lot of primary teeth. If your child has a high caries rate with incipient watch areas between their teeth, these radiographs will need to be taken at 6 month intervals.

PANORAMIC: A panoramic view of the entire mouth. This radiograph provides an overall view of the teeth including unerupted teeth, any missing or extra teeth, the sinus cavity, the bone, the root structure and impacted teeth. This radiograph also shows any cysts, tumors, bone and/or root abnormalities, root canals and a general view of the periodontal health and growth and dental development. This radiograph points us to areas that may need attention and a further single periapical radiograph. We update a panoramic radiograph every 3-5 years, and the first one should be taken by the time your child's first permanent tooth erupts into their mouth (usually age 5-6 years). A panoramic is also indicated in certain trauma cases.

PERIAPICAL RADIOGRAPHS: This single radiograph is taken to view the root and surrounding bone structure of a tooth. A tooth that is sensitive to hot, cold, sweet, pressure or teeth that have sustained trauma will require a follow-up for root canals and trauma. It is difficult to say how often these are updated. They are taken normally on an as-needed basis. Horizontally positioned radiographs called occlusals are usually the first ones we take by age 2-3 years. This is to rule out decay and assess the underlying developing tooth structures. It also provides us with a baseline should your child suffer trauma to their front teeth.

FULL MOUTH RADIOGRAPHS This is a set of 16-20 radiographs that include bitewing and periapical radiographs of each tooth. This is seldom needed for young children due to the ability to visualize most things with the bitewings (because children have such small mouths). A full mouth set may be necessary in older children and teenagers for complete diagnosis and assessment of periodontal health.

There has always been a concern about exposure to radiation. Our equipment is modern, digital and tested regularly for radiation leakage. We provide Kevlar or lead shields to prevent minute scatter radiation that may be present. Exposure to the sun's rays or flying in an airplane for a couple of hours is normally more radiation exposure that a full mouth series of dental radiographs. If there is a chance that you or your child may be pregnant, it is important that you inform us immediately so that we might avoid any exposure to the unborn child.

Dr. Gonzales and Dr. Wickersham will evaluate your child's dental health and determine what radiographs are needed for proper diagnosis. We tailor our care to your child's needs, and we do not believe in taking excessive X-rays. We will only take radiographs that are essential to your child's complete diagnosis. We will provide estimated fees for radiographs upon your request. Please understand that at times, your child's behavior may not permit us to take all the radiographs needed for a complete diagnosis. We will inform you if this occurs, and Dr. Gonzales and Dr. Wickersham will advise of the possible consequences.

I have read the radiograph (X-ray) information and I understand the treatment philosophy of Dr. Gonzales and Dr. Wickersham. I understand that there may be some services that my insurance carrier does not cover and I will be responsible for any expenses incurred.

Signed _____ Relationship to child _____Date _____