Welcome to Pediatric Dentistry of Round Rock

We would like to welcome you and your child to our office. Our goal is to make every child's visit pleasant and educational. We strongly emphasize preventive care, and strive to teach good dental care that will enable your child to have a beautiful smile that lasts a lifetime.

1 ABOUT YOUR CHILD

Name: _____
(Last) (First) (MI)
Nickname: _____ ☐ Male ☐ Female
Birthdate: _____ SSN: _____
Home Address: _____
_____
(Apt #) (City) (State) (Zip)
Home Phone: _____School_____ Grade___
Brothers/Sisters (Names) _____
Child's hobbies, favorite games_____
Referred by: _____

2 ABOUT MOM

Your name: _____
Your phone and address if different from child's
Home phone: _____
Address: _____
_____
Occupation: _____
Employer: _____
Work phone #: _____Ext: _____
Cell phone/beeper#_____
Email _____

3 DENTAL INSURANCE

Dental Ins. Co: _____
Insurance Co. Phone #:_____
Group/Policy #: _____
This dental insurance is provided through:
Insured's name: _____
Insured's Social Security #:_____
Relationship to child: _____
Insured's birthdate:_____
Insured's employer: _____

4 ABOUT DAD

Your name: _____
Your phone and address if different from child's
Home phone: _____
Address: _____
_____
Occupation: _____
Employer: _____
Work phone #: _____Ext: _____
Cell phone/beeper#_____
Email _____

5 DENTAL HISTORY

Is this your child's 1st dental visit?____ If no, what was the approximate date of the last visit?_____
Was there a previous unfavorable medical/dental experience? _____ If so, please explain:_____
_____
Does your child receive fluoride tablets, drops, vitamins, or a rinse?_____
Is your home supplied with well water or city water? _____
Does your child brush his or her teeth daily? _____ Do you assist them? _____
At what age was bottle or breast feeding stopped? _____

Does your child have any of the following:
____ Dental Pain ____ Swelling ____ Cavities ____ Sores in Mouth ____ Injured Teeth
____ Thumb/Pacifier Habit ____ Sealants ____ Extracted Teeth ____ "Crooked Teeth"

What do you predict your child's behavior to be: ☐ Cooperative ☐ Fearful ☐ Defiant ☐ Don't Know
What are your concerns about your child's oral health/teeth?_____
_____

6

MEDICAL HISTORY

Has your child ever had one of the following conditions?

Please circle:

Y N Anemia
Y N Asthma, Lung Problems
Y N Autism
Y N ADHD / ADD
Y N Birth Defects
Y N Bleeding Problems
Y N Blood Pressure Problems
Y N Cerebral Palsy
Y N Cleft Lip/Palate
Y N Delayed Development
Y N Diabetes
Y N Heart Problems/Murmurs
Y N Ear Infections
Y N Fainting Spells
Y N Hearing Loss/ Impairment
Y N Herpes
Y N Kidney Disease
Y N Liver Disease/Hepatitis
Y N Malignancy, Cancer
Y N Latex Allergy/Sensitivity
Y N Mental/Emotional Problems
Y N Pregnant
Y N Premature/Low Birth Weight
Y N Psychiatric Problems
Y N Immunologic Disorders/HIV
Y N Rheumatic Fever
Y N Seizures/Epilepsy
Y N Sickle Cell Anemia/Trait
Y N Speech Problems

Is your child allergic or had any adverse reaction to a medication? Y N

If yes, please list:_____

List any medications your child is currently taking, the dosage, and what it is taken for_____

_____

_____

Has your child ever been hospitalized or treated in an emergency room?

Why? _____ When?_____

Child's Physician_____

Last Exam _____

Physician's phone#_____

_____

Any problems not listed above:_____

_____

_____

_____

CONSENT FOR TREATMENT

(State law requires us to obtain your consent for contemplated dental treatment or oral surgery. Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain it.)

I understand that the information that I have given is correct to the best of my knowledge. I understand that this information will be held in the strictest of confidence, and that it is my responsibility to inform this office of any changes in my child's medical status. Your child is a minor, therefore it is necessary that a signed permission be obtained from a parent or guardian before necessary dental services can be started. I authorize, request, and permit Dr. Bookmyer and any employees/staff under her direct supervision to provide any dental/medical treatment necessary in connection with my child. This includes the use of any necessary or advisable local anesthesia, radiographs (X-rays) or diagnostic aids.

In general terms dental treatment may include:

A. Cleaning of the teeth and application of topical fluoride.
B. Application of plastic "sealants" to the grooves of teeth.
C. Treatment of diseased or injured teeth with dental restorations (fillings or crowns).
D. Removal (extraction) of one or more teeth.
E. Treatment of malposed "crooked" teeth and/or oral development or growth abnormalities.
F. Use of sedative nitrous oxide/oxygen if needed to assist in a more pleasant dental treatment.
G. Other_____

Good results are expected, however I am advised of the possibility of unanticipated complications. Therefore there can be no guarantee expressed or implied either as to the result of the treatment or as a cure.
Although their occurrence is extremely rare, some risks have been reported to be associated with dental or oral surgery procedures. State law requires us to mention the possible risk of infection, swelling, numbness, bleeding, discoloration, aspiration of foreign objects, vomiting, nausea, and allergic reactions. I further understand and accept that complications may require hospitalization and may even result in death. I hereby state that I have read and understand this consent, and that all questions have been answered in a satisfactory manner. I understand that I have the right to be provided with answers to questions which may arise during the course of my child's treatment. I further understand that this consent will remain in effect until such time that I choose to terminate it.

Signature_____ Relationship to child _____ Date_____

Pediatric Dentistry of Round Rock

PATIENT CONSENT FORM/

HIPAA COMPLIANCE

Out Notice of Privacy Practices provides information about how we may use and disclose protected health information about you or your child. This notice contains a patient rights section describing your rights under the law. You have the right to review our notice before signing this consent. The terms of our notice may change. If we change out notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you or your child is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you or your child for treatment, payment and health care operations. You have the right to revoke this consent, in writhing, signed by you. However, such a revocation shall not affect any disclosure we have already made due to your prior consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected health information may be disclosed or used for treatment, payment, or health care operations.
- The practice has a Notice of Privacy Policies and the parent/guardian of the patient has the opportunity to review this notice.
- The practice reserves the right to change the Notice of Privacy Practices.
- The parent/guardian of the patient has the right to restrict the use of their information, but the practice does not have to agree to those restrictions.
- The parent/guardian of the patient may revoke this consent in writing at any time, and all future disclosures will then cease.
- The parent/guardian of the patient gives authority to send dental records to other dentists via electronic means (email).

This consent was signed by:_____

Signature of Parent or Guardian

Relationship to patient (if other than parent):_____

Date:_____

Witness:_____

Pediatric Dentistry of Round Rock Financial Policy
Dr. Kelsey Bookmyer & Dr. Sage Thames

We are delighted to have your child as a patient. We look forward to keeping your child in tip top dental health and watching them grow over the years. Our office policies and financial agreement is listed below. If you have any questions we would be happy to answer them.

Appointments

It is very important that we receive 24 hour notice in the event that you need to cancel an appointment. We reserve time especially for your child, and have prepared in advance for your dental appointment. If you cancel with less than 24 hour notice, you will be charged a **$25.00 fee**.

Please be on time for your reserved appointments. If you are 15 or more minutes late for your appointment it will be considered a "no show" and will need to be rescheduled in order to have adequate time for your child's care.

(Initials_____)

Insurance

As a courtesy to you, we will be happy to file your **primary** dental insurance. As an open access practice we can file all PPO plans as a "non-contracted" provider. PPO plans have both in and out of network benefits. **Estimated patient out-of-pocket amounts and deductibles are due and payable at the time of service**. The benefits quoted are not a guarantee of payment and benefits not paid by the insurance company are the responsibility of the patient. In the state of Texas, insurance companies have up to 30 days to process a claim. If your insurance carrier has not responded in that time, we will contact you to keep you updated on your claim's status and may ask you to call your insurance company.

(Initials_____)

Office Policy and Payment Responsibility

Our office makes every effort to verify your benefits before treatment. We can only estimate what your insurance will cover and any financial limitations they may place on our services. We will strive to estimate your insurance's benefits and limitations; however, you may receive a statement or reimbursement after your claim has been processed. Regardless of who provides the dental insurance for the child, the parent/guardian **who signs the treatment consent** is responsible for payment.

(Initials_____)

Treatment Deposit

If your child's treatment includes sedation, a deposit of $325.00 is required to schedule the appointment. The deposit is non-refundable if the appointment is cancelled without giving 24 hour notice. Larger treatment cases also may require a deposit. The deposit money will be applied to your overall treatment cost.

(Initials_____)

Payments

- Payment is due when services are rendered. An estimate of your child's treatment fees will be outlined in detail with you at the time of your initial visit, or at a follow up treatment consultation.
- We accept Visa, MasterCard, Discover, American Express, cash and personal checks with proper identification.
  (Returned checks may be recovered electronically along with a state allowed recovery fee.)
- If financing is needed, we offer that through an outside company called **Care Credit** and will be happy to explain the terms. Please ask our front desk personnel for more information.

(Initials_____)

I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Parent or Responsible Party's Signature_____Date_____