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: _____

Please See Back

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: _____

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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? _____

Any family history of complications to surgery and/or anesthesia?

_____

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

Other_____

- ◯ 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

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: _____

Fadal Pediatric
DENTISTRY
#5 Doctor Circle | Longview, Texas | 903-21BRUSH

Consent/Authorization for Dental Treatment of a Minor

All minors seeking dental treatment MUST be accompanied by a parent/legal guardian during the initial office visit. Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances, however, we MUST have written authorization allowing this person to accompany your child. The person bringing your child will need to present photo identification at time of service. This person will also be authorized to do the following unless noted otherwise:

- To sign any and all forms required to give permission to Fadal Pediatric Dentistry to treat the dental needs of the patient
- To discuss finances (treatment charges, account balances, and next appointment charges)
- To discuss the patient's future dental treatment needs
- To sign the patient's treatment plan once it has been presented (I understand that this does not obligate me to the treatment, only that the office has informed me or my representative of the dental needs of the patient)

Patient's Name: _____ Patient's DOB: _____

Person(s) allowed to bring the patient to the appointment:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

If only parent(s) are allowed to bring the patient, please write PARENT ONLY.

Signature Parent/Guardian: _____ Date: _____

Department of State Health Services
Notice of Privacy Practices

ACKNOWLEDGEMENT OF REVIEW

Date: _____

I have reviewed the Department of State Health Services Notice of Privacy Practices (version effective July 20, 2015), which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this notice if requested.

_____ _____

Patient Name (Print) Patient Signature

If completed by a patient's personal representative, please print and sign your name in the space below.

_____ _____

Personal Representative (Print) Personal Representative Signature

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 be specific):

_____

_____

_____ _____

Employee Signature Date

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.**
- I understand that should my insurance company send payment to me, I will forward the payment to Fadal Pediatric Dentistry **within 48 hours.**

AS FOR THE MATTER OF DIVORCED PARENTS: Payment is the responsibility of the parent who brings the child in the office for treatment. This is regardless of the terms outlined in a divorce decree. This is a matter between the divorced parties and the courts and we cannot be placed in the middle. If the divorced parents cannot agree on treatment for their child we may not be able to continue to treat them.

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 ($35 service charge on all returned checks)
All major **credit cards**
CareCredit 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.
3. I authorize my insurance company to pay my benefits directly to Fadal Pediatric Dentistry & I understand that I will be fully responsible for any outstanding balance on my account. This is a direct assignment of right & benefits under this policy.

Signature of responsible party Date

SCHEDULING GUIDELINES & RESPONSIBILITIES

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 child's 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 without calling in advance, it will be necessary to dismiss the patient and family from our practice.** And after that time we will only see the patient on emergency basis for the following 30 days.

Any **treatment appointments** that are not confirmed a day before by 2:00pm will have to be **CANCELLED**. Please make sure to **ALWAYS** confirm every single appointment.

Our late grace period is ONLY 10 minutes, we will have to reschedule ALL late appointments. Please be mindful and try to make all your appointments on time.

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_____