Texas Tiny Teeth
PEDIATRIC DENTISTRY

Welcome to Our Practice!

Child's Name: _____ Date of Birth: _____

Gender: (Circle one) Male / Female

Emergency Contact (name and phone number): _____

How did you hear about our office?

- Friend (name)_____
- Drive-by
- Google or Facebook
- Other_____
- Other Dentist (name) _____
- Pediatrician name) _____
- Insurance Referral
- Sibling is already a patient

Parent Information

Mother's Information: (Circle one) Mother Step-Mother Foster Mother Guardian Grandma

Name:	**DOB:**	**Occupation:**
Address:	**SSN:**	**Employer:**
City, State, Zip:	**Marital Status:**	**Does child live with you?** **Yes / No**
Home Phone:	**Cell Phone:**	**Work Phone:**
Email Address:		

Father's Information: (Circle one) Father Step-Father Foster Father Guardian Grandpa

Name:	**DOB:**	**Occupation:**
Address:	**SSN:**	**Employer:**
City, State, Zip:	**Marital Status:**	**Does child live with you?** **Yes / No**
Home Phone:	**Cell Phone:**	**Work Phone:**
Email Address:		

Health Information

Previous DDS: _____ Date of last visit: _____ Reason for visit: _____

Times a day child brushes: _____ Times a week child flosses: _____ Is your water fluoridated? Y / N

How would you rate your child's hygiene? Worst – 1 2 3 4 5 6 7 8 9 10 -- Best

Does your child have any oral habits? • Thumb/Finger Sucking • Tongue Thrusting/Sucking • Grinding
• Heavy Snoring • Mouth Breathing • Lip Sucking
• Breast feeding • Bottle at bed time • Pacifier

Does your child have or ever had any of the following diseases, medical conditions or procedures? Please check those that apply: **(By circling "NONE" you agree that you have read ALL conditions and that NO conditions currently apply to the child.)**

• Aids/HIV/ARC	• Diabetes	• Liver Disease	Please explain any checked
• Allergy to medication	• Difficulty with speech	•Mental Disorders	responses _____
• Allergies (environmental)	• Epilepsy/Seizures	• Mouth Injuries	_____
• Allergies Food/Dye	• Excessive bleeding	• Prolonged bleeding	_____
• Allergies to Codeine	• Head injuries	• Radiation Treatment	_____
• Allergy to Latex	• Hearing Problems	• Respiratory Problems	_____
• Allergy to Penicillin	• Heart Disease	• Rheumatic Fever	_____
• Anemia	• Heart murmur	• Rheumatoid Arthritis	_____
• Artificial bones / joints	• Hepatitis (A, B, C)	• Sickle Cell Trait	_____
• Asthma / Lung Problems	• High Blood Pressure	• Sinus Problems	_____
• Autism	• Hospitalization / Surgery	• Stomach Problems	_____
• Birth Defects (explain)	• Hyper/ADHD/ADD	• Stroke	_____
• Cancer / Tumors	• Jaundice	• Tuberculosis TB	_____
• Cerebral Palsy	• Kidney Disease	• Ulcers	_____
• Cleft Lip / Palate	• Leukemia	• Other _____	• NONE

List all current medications: _____
_____

Is the child taking any of the following? • Pain Medications • ADD/ADHD Meds • Blood Thinners
• Tranquilizers • Insulin • Muscle Relaxers • Other_____

Name of Physician / Pediatrician _____ Phone # _____

_____ _____
Signature of Parent / Guardian Date

Medical / Dental Release Statement

I give my consent for the doctor on staff for Texas Tiny Teeth Pediatric Dentistry to do a complete and thorough examination on the patient previously named, including any diagnostic radiographs needed. To the best of my knowledge, the information that I have given is correct and I understand that it will be held in the strictest of confidence. Furthermore, I understand that it is my responsibility to inform Texas Tiny Teeth Pediatric Dentistry of any future changes to my child's medical status. As the parent or legal guardian of the previously named patient, I do hereby grant the doctor and his staff permission to perform any needed treatment(s). I also understand that all necessary treatment will be explained prior to commencement and that I am responsible for payment in full at the time of service, unless prior arrangements have been approved.

Requirement for Filing Insurance Claims:

To precipitate the filing of my dental insurance claims, I do hereby authorize the release of confidential information to my dental insurance agency and understand that I am personally responsible for any balance remaining after the insurance payment has been received. I am also fully responsible if my insurance policy fails to pay, for any reason, within 60- days of treatment. I hereby authorize payment of insurance benefits directly to Texas Tiny Teeth Pediatric Dentistry. Furthermore, in the event of payment default for services previously rendered, I also agree to pay all reasonable collection and/or legal fees incurred in an attempt to collect on this amount.

I will follow all post-operative instructions and if my child is sedated for treatment I will review aftercare instructions and follow doctor's directions to insure recovery of my child. Any emergencies after hours I have been advised to go to the emergency room nearest me.

I have been informed to call the office at 903-402-3200 and follow prompts to let after hours clinical employee on call know that I have taken my child to the emergency room.

_____ _____

Signature of Parent / Guardian Date

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HIPAA Consent Agreement (Privacy Act)

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 care among the multiple healthcare providers who may be involved in that treatment directly or indirectly
- Obtain payment from designated third-party payers.
- Conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by you of your Notice of Privacy Practices that contains a more complete description of the uses and disclosures of my health information (available at the following link HIPAA Notice of Privacy Practices or in office in print form).

I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that Texas Tiny Teeth has the right to change its Notice of Privacy Practices from time to time and that I may contact Texas Tiny Teeth at any time to obtain a current copy of the Notices of Privacy Practices.

I understand that I may request in writing that Texas Tiny Teeth restricts how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Texas Tiny Teeth is not required to agree to my requested restrictions, but if Texas Tiny Teeth does agree, then it is bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that Texas Tiny Teeth has taken action relying on this consent.

_____ _____

Signature of Parent / Guardian Date

Parental Guidelines in Our Office

Dear Parents,

We want your child to receive the best possible care at our office. We feel this is a joint process in which parents will play a pivotal role. The dental clinical area serves multiple functions - we see patients for regular cleanings and examinations as well as for more invasive procedures. We would like to clarify what the clinical areas are used for and how you can maximize the outcome for your child.

Dental offices perform both non-invasive and invasive procedures at the same time in the clinical area. Your child's regular check-ups are considered non-invasive, while dental surgery and operative are considered invasive.

As a parent, we know how much time you've spent in your child's physician's office and we, as dentists, share some similarities with them, most notably seeing several patients throughout the day for non-invasive procedures. The most notable difference is that a physician will perform his invasive surgeries in an outpatient setting or a hospital where only staff and doctors are present. A dentist performs his surgical and operative procedures in the same area and at the same time our non-invasive patients are seen. The dentist requires the same level of concentration given the physician in his controlled environment. Minimum movement and distractions in and about the operative area are crucial for optimum care of the children. NO parents will be allowed in the clinical area during sedation.

You may choose whether to accompany your child to his/her cleaning check-up appointment. Although we sense some children do better without parents' present, we are open to having you present with your child. If you choose to be present, we suggest the following guidelines to improve chances of a positive outcome:

Parents are not allowed in the clinical areas during invasive procedures. They are also not allowed in the clinical area for any type of sedation, surgery or IV appointment. You may be allowed to accompany your child until medication takes effect in our cozy room then you will be asked to wait in the reception area until treatment is completed and your child is in the recovery area.

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You can assist us by following a few guidelines:

1. Allow us to prepare your child
2. Be supportive of the practice's terminology
3. Please be a SILENT OBSERVER. That means no talking during dental procedures.

Support your child with touches

a. This allows us to maintain communication with your child
b. Children will normally listen to their parents instead of us and may not hear our guidance
c. You might give incorrect or misleading information
4. If asked to leave, be ready to immediately walk away
a. Many children will try to control the situation
b. "Acting out" is normal, but unacceptable and unsafe during your child's visit to our office
c. This is intended to "short circuit" the control attempt
d. We will continue to support your child at all times

Following these few simple guidelines will help to insure the best possible results.

I have read the above information and have been explained the office policy on parental presence in the clinical area.

_____ _____

Signature of Parent / Guardian Date

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Financial policy

We appreciate you choosing our office for your child's dental care. At Texas Tiny Teeth, we value our relationship with your family and would like to offer the following as our payment policy.

If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and co- payments at the time of service. You are responsible for paying all charges not covered by your insurance company, including all fees considered above your insurance company's usual and customary fee schedule. Your insurance benefits are a contract between you and your employer. The amount of coverage you receive will depend on the quality of the plan purchased by your employer, not the fees of Texas Tiny Teeth.

In case of insurance, we will be happy to help you receive the maximum benefits available under your policy. As a courtesy, we will file your insurance benefits for you after every visit. However, please realize that the relationship is between you, the insured, and your insurance company.

If we do not receive payment from your insurance company within 60 days after submission of claim, you will be required to pay for all dental services in full.

Once the treatment plan and estimated insurance benefits are reviewed with you, we ask that you pay your out of pocket portion in full at the time of service.

If you are ever unable to keep a cleaning and check-up appointment, please call us at least 24 hours in advance to reschedule to avoid a $25 no show fee.

If you are ever unable to keep a TREATMENT appointment, please call us at least 48 hours in advance to reschedule to avoid a $25 no show fee.

Please note that parents or guardians bringing the child into the office on the day of the service will be expected to pay for services rendered.

_____ _____

Signature of Parent / Guardian Date