PATIENT INFORMATION

NAME ____ **GENDER:** ☐ **MALE** ☐ **FEMALE**
Last **First** **Middle**

NAME YOUR CHILD PREFERS TO BE CALLED: ____

BIRTHDAY _____ / _____ / _____ **AGE** ____ **WEIGHT** ________ **SOCIAL SECURITY NUMBER** ____ / ____/ _____

Have we seen another child in your family? Y N If yes, please list/Dr. seen? ______________________________

Which Dentist is your child's appointment with today? ☐ Dr. Harris ☐ Dr. Meredith ☐ Not Sure

Who is your dentist? ______________________ ☐ Do not currently see a dentist ☐ Would like a recommendation

How did you hear about our office? (please mark all that apply and specify whom if applicable)

☐ Phonebook ☐ Social Media (Facebook, Instagram, etc.) ☐ Internet (Google, Yahoo, etc) ☐ Print Ad ☐ TV/Radio

☐ Friend/Relative ________________ ☐ Physician/Dentist ________________ ☐ Other ______________

Who has legal guardianship of child:

________________________________ ________________________________
Name/ Relationship Name/ Relationship

Child currently lives with:

________________________________ ________________________________
Name/ Relationship Name/ Relationship

We would like to know a little about your child and what he/she likes: Pet's name: ______________________

Favorite color:______________________________ Hobbies: ______________________________

EMERGENCY INFORMATION

Name of nearest relative/friend not living with you__________________**Relationship**____________________

Complete Address ____**Phone** ________________

HAS YOUR CHILD:

☐ Yes ☐ No Ever visited the dentist before?

Name of Dentist____________________________ City/State____________________________

Date of last visit?____________________________ Were x-rays taken? ________________________

☐ Yes ☐ No Ever had an unfavorable dental/medical visit? If yes, please explain:____________________

____

Form 23/Rev 09.18

Pediatric Dental Specialists PA, 2921 N. Heritage Parkway, Suite 100, Sherman, Texas 75092 (903)892-1200 Fax (903) 813-1581
www.shermankidsdentists.com

Patient Name: ________________________ **Age:**_______ **Date of Birth:**__________________ **Gender: M F**

Pediatrician/Primary Care Provider: ____________________________________ **Phone Number:**___________________________

Has your child been seen by a specialist: ☐ No ☐Yes If yes, please indicate reason:____

Specialist(s) Name: ____ **Phone Number:** ________________________

Orthodontist: ___________________________________ **Date of last visit:**__________________

Rate your child's medical health: ☐ Good ☐ Fair ☐ Poor **Immunizations up to date:** ☐ **No** ☐ **Yes** ☐ **Do not immunize**

Do you consider your child to be: ☐ advanced in the learning process ☐ progressing normally ☐ slow in the learning process

Does your child have or have they ever had any of the following:

Y	N		Y	N		Y	N	
☐	☐	Heart Murmur / Heart Problems	☐	☐	Lung Issue / Cystic Fibrosis	☐	☐	Autism / ASD
☐	☐	Allergy to LATEX	☐	☐	Asthma (Last Attack__________)	☐	☐	Physical / Mental Impairments
☐	☐	Allergy to DYES				☐	☐	Learning Disability / Dyslexia
☐	☐	Shunt	☐	☐	Anemia / Sickle Cell	☐	☐	Developmental Delay
☐	☐	Rheumatic Fever	☐	☐	High Blood Pressure	☐	☐	Behavioral / Personality / Social Disorder
☐	☐	Hemophilia / Bleeding Problems	☐	☐	HIV Positive / AIDS			
☐	☐	In-dwelling Catheter	☐	☐	ADD / ADHD	☐	☐	Dermatologic or Skin Conditions
			☐	☐	Frequent Headaches	☐	☐	Anesthesia / Anesthetic Issues
☐	☐	Cancer / Chemo / Radiation	☐	☐	Hearing Impairment	☐	☐	Glaucoma
☐	☐	Organ Transplant ____________	☐	☐	Speech Issues	☐	☐	Sleep Apnea
☐	☐	Kidney Issue / Disease	☐	☐	Acid Reflux / GERD	☐	☐	Sleep Disorders
☐	☐	Diabetes (Last count__________) Time taken____________)	☐	☐	Convulsions/Seizures/Epilepsy	☐	☐	Currently taking birth control
			☐	☐	Muscle Issues	☐	☐	Seasonal Allergies
☐	☐	Liver Issue / Hepatitis	☐	☐	Pregnancy	☐	☐	Strong / Excessive Gag Reflex
☐	☐	Digestive / Bladder Issues	☐	☐	Weight Issues	☐	☐	Other_____________________

Medicines (Prescription, Over-the-Counter, Herbal): ☐ **No** ☐ **Yes Please list:** ____
____

Allergies (Medication/Food/Other Product): ☐ **No** ☐ **Yes: Please list:** ____

Does your child require antibiotics prior to dental treatment (heart murmur, shunt, prosthetic device, pins/screws, etc.): ☐ **No** ☐**Yes**

Has your child had: ☐ No ☐Yes **Tonsils Removed** ☐ No ☐Yes **Hospital stays/operations** ☐ No ☐Yes **Pins/Screws If yes to any, please describe with dates:**____

Has your child been seen, needed to be seen, diagnosed and/or treated by a healthcare provider for any of the following:

☐ No ☐Yes Sickness, fever, congestion, upper respiratory/sinus infection in the last 2 weeks. ☐ No ☐Yes Ear infection in the last 4 weeks.

☐ No ☐Yes Ongoing Staph/MRSA infection in the last 4 weeks. ☐ No ☐Yes Strep throat in the last 2 weeks.

☐ No ☐Yes Lice, Pink Eye, Poison Ivy/Oak last 2 weeks. ☐ No ☐Yes Contagious illness in last 4 weeks.

If yes to any, by whom was your child seen and when:____

Person Accompanying Child: Are you: ☐**Parent** ☐ **Step-Parent** ☐**Grandparent** ☐**Other (Please specify)** ____________________
Name (Please Print):____**Phone:**___________________________

Do you have any concerns for today's visit? ☐ No ☐Yes **(If yes, please list)** ____
____

Has your child been seen by another dentist or dental specialists since their last visit here: ☐ **No** ☐**Yes If yes, please describe:**
____ **Were x-rays taken:** ☐ **No** ☐ **Yes**

Does your child have any dental problems that you are aware of, including tooth pain/injury to the mouth/teeth/jaws? ☐ **No** ☐ **Yes**
If yes, please explain: ____

The information I have given is correct to the best of my knowledge and I understand that it will be held in the strictest confidence. I understand it is my responsibility to inform this office of any changes in my child's medical status, address, phone number, email address or any other personal information. I give Pediatric Dental Specialists, P.A. permission to perform cleaning, x-rays deemed necessary for diagnosis, examination, fluoride treatment, and (sealants if applicable with prior authorization). In case of an emergency, I hereby authorize Pediatric Dental Specialists, P.A. to perform emergency and/or life-saving treatment for my child.

______________________	______________________	______________________	____________
Patient or legal guardian if a minor)	Print Name	Relationship	Date

_____ **I give permission to Pediatric Dental Specialists, P. A. to use my child's first name and picture in their website (www.shermankidsdentists.com) or social media (i.e. Facebook page, Instagram, etc.) for future promotions and announcements.**

For Office Use Only

Provider: Harris Meredith

Medical History Reviewed By_____________________________

Time_______ **Age**________ **Weight**__________ **BP**__________ **Pulse**__________ **O2 Sat**__________ **ASA**__________ **TX Y N** Form 16/Rev 01.19

RESPONSIBLE PARTY INFORMATION

Patient Name: ____
First **Middle** **Last**

MOTHER / LEGAL GUARDIAN (Please circle) Name____
Last First Middle

Address ____
Street/PO Box City State Zip

Date of Birth _____/_____/_____ Social Security # _____/_____/______ Do you want to be contacted by Email? Yes_____ NO______

Driver's License # ___________________ State _____ E-mail Address ______________________________

Phone Numbers- Home_________________________ Cell______________________ Work______________________

Place of Employment ______________________________Occupation______________________________

Name of Spouse (if different than Father/Legal Guardian)______________________________

FATHER / LEGAL GUARDIAN (Please circle) Name____
Last First Middle

Address____
Street/PO Box City State Zip

Date of Birth _____/_____/_____ Social Security # _____/_____/______ Driver's License # ____________________ State _________

E-mail
Address____

Phone Numbers- Home_______________________ Cell___________________ Work___________________

Place of Employment __________________________Occupation______________________________

Name of Spouse (if different than Mother/Legal Guardian) ______________________________

INSURANCE INFORMATION

If covered by traditional dental insurance please complete the following:

Insured's Name ____
Last First Middle

Social Security/ID#__________________ Date of Birth_____/_____/_____Relationship to Patient ____________________

Insurance Company___________________ Phone #____________ Employer______________________ Group #______________________

Insured's Name ____
Last First Middle

Social Security/ID# __________________ Date of Birth _____/_____/_____ Relationship to Patient____________________

Insurance Company_________________ Phone #_____________ Employer_____________________Group #________________________

Please initial below:

_________ By signing this form, I agree to take full financial responsibility for this child's account independent of what a divorce decree may state. If dental insurance is applicable, I understand that my estimated portion of the treatment amount is due at the time of service and that any amount left unpaid by insurance is payable by me within 30 days. I understand that a FINANCE CHARGE with an Annual Percentage Rate of 18% will be imposed on any account balance 60 days or more outstanding.

_________ I hereby authorize payment of dental insurance benefits, if any, to be made directly to Pediatric Dental Specialists, P.A.

Signature of person completing form ____Date ____________________

Printed name____Relationship to Patient ________________________

Form 30/Rev. 10-13

Oral Health Questionnaire For ____ Age: ______

Filled Out by: _______________________________ Relationship to Patient:_____________ Date: ____________

Health History	Y	N	N/A	Comments
Did birth mother have problems during pregnancy?				
Was child premature and/or have low birth weight/ complications at birth?				
Diet and Nutrition				
Is/was the child breast fed? If so, for how long?				
Does child sleep with a bottle? (if applicable)				
How many times does child have: Something to drink each day? ______ times. Snacks each day? ______ times				
Is child on a special diet?				
Fluoride Adequacy				
What is child's source of water (well, tap, bottled, etc)				
Do you use fluoride toothpaste for the child? Date started?				
Oral Habits				
Does child use a pacifier? (If applicable)				
Does child suck a thumb or fingers?				
Does child grind his/her teeth day or night?				
Injury Prevention				
Do you use a car seat for child? (If applicable)				
Does the child play sports? (If applicable) Use mouthguard? Y N				
Has child had an injury to his/her mouth or face?				
Oral Development and Dental History				
Child's age (in months) when the first tooth came in? _______				
Have you noticed any problems with child's mouth/teeth?				
Does child complain of mouth pain?				
Have any of your children ever had cavities?				
Do you have any cavities?				
Do your gums bleed?				
Have you or anyone in your family had extra or missing teeth? Y N				
Have you or your children ever had a bad dental experience?				
Oral Hygiene				
How often does child brush each day? _____ Floss?_____				
Do you help child brush? _____ Floss?_____				

AUTHORIZATION FOR TREATMENT OF A MINOR
Please include any/all children you are authorizing consent for:

I, ________________________________, parent(s)/legal guardian(s) of:

__________________________________, a minor child born on ____/____/____,

__________________________________, a minor child born on ____/____/____,

__________________________________, a minor child born on ____/____/____,

__________________________________, a minor child born on ____/____/____,

__________________________________, a minor child born on ____/____/____,

__________________________________, a minor child born on ____/____/____,

Hereby authorize other than legal parent / guardian:

______________________________________ ______________________________________
(Name) (Relationship to child) (Name) (Relationship to child)

______________________________________ ______________________________________
(Name) (Relationship to child) (Name) (Relationship to child)

to give consent for the dental treatment of the above named child(ren) for any dental condition that he/she may encounter; or to bring the child(ren) to PDS for routine checkups and associated procedures deemed necessary by PDS. I also authorize the dentist, hygienists, and staff at PDS to give information to the individual(s) named above regarding the diagnosis and plan of treatment, or any information necessary for the care of the above named child(ren).

• I hereby release PDS of any liability regarding release of this information on the above named child(ren).

• I understand that if someone other than the above listed on this form brings my child(ren) to the dental appointment, my appointment will be rescheduled for another time.

• I understand that only the above listed have permission to make decisions regarding my child(ren)'s dental treatment, and it is my or other legal guardian's responsibility to notify PDS of any desired changes.

• I understand changes can be made by a parent or legal guardian at anytime by filling out a new authorization for treatment of a minor, as these changes are not considered addendums to the existing form.

• I understand that even though I have authorized the above named to make treatment decisions regarding the above named child(ren), I will be financially responsible for this family account, and **I understand that payment is due at the time of service.**

____ ____
Parent/Legal guardian Date Parent/Legal guardian Date

Please INITIAL if applicable:

______I hereby authorize my child (age 15 with proof of hardship license, or 16 and above) to receive dental treatment (i.e. dental exams, x-rays, cleaning, fluoride, treatment with or without nitrous oxide but excluding oral sedation) without an authorized person accompanying him/her. I understand that a parent or legal guardian will be responsible for completing the medical history and all necessary paperwork prior to the appointment until my child is 18 years of age.

2921 N. FM 1417 (Heritage Parkway) Suite 100 Sherman, TX 75092 (903) 892-1200 fax: (903) 813-1581
www.shermankidsdentists.com

MEDICAL RELEASE AND ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

Please include any/all children you are giving authorization for:

____________________________________, a minor child born on ____/____/____,

____________________________________, a minor child born on ____/____/____,

____________________________________, a minor child born on ____/____/____,

____________________________________, a minor child born on ____/____/____,

____________________________________, a minor child born on ____/____/____,

____________________________________, a minor child born on ____/____/____,

I, __________________________________, am giving my permission to Pediatric Dental Specialists, PA
Parent / Legal Guardian (please print)

and my child(ren)'s Health Care Provider(s) to communicate and exchange health care information as it relates to their health and dental needs.

I understand I can receive a written copy of this office's Notice of Privacy Practices at my request.

____ __________________________
Signature of Parent or 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)

Form 22/ Rev. 9/18

PEDIATRIC DENTAL SPECIALISTS, P.A. ***OFFICE POLICIES***

Welcome to our practice! We are excited you have chosen our team of professionals to create positive smiles for your child(ren). To better serve you, we have prepared our office policies so that you may have an understanding of how our practice functions. If you have any questions, please feel free to ask.

PATIENTS

- We are ***PEDIATRIC DENTAL SPECIALISTS!*** That means we specialize in dental treatment for children. From the appearance of an infant's very first tooth until that same child graduates from high school, we want to be personally involved in maintaining a dazzling smile! Most children should be seen for the first time when the first tooth erupts or by one year of age, however we are happy to see infants and children of all ages. Our professional staff is skilled in making sure each child has a positive dental experience in our office!

APPOINTMENTS

- Dental decay is the number one disease among children. Many children in the Texoma area suffer from tooth decay. As a result, we have a long list of children who are waiting to be seen for an initial appointment. We have specifically scheduled an appointment for your child. We ask that you please be on time (preferably early!) for your appointment as we try to see each patient within 10 minutes of his/her appointment time. Because the appointment time has been specifically created for your child, we reserve the right to reschedule your child's appointment to another time if you are 15 minutes or more late (in consideration for our other patient families).
- It is the policy of this practice to exclusively treat children and the special needs patient. Children tend to react to the fears and concerns of their parents, and it is our experience that they are more responsive and cooperative to treatment if parents are not present during treatment. Because dental treatment is a surgical procedure, we want 100% of our attention to be on your child and your child's care. Therefore, we respectfully require that you remain in the waiting room while your child is being treated. **Parents should NOT LEAVE the waiting room area during the child's treatment**. This will enable us to have immediate access to you should we need additional information regarding your child. Once your child's treatment is complete, the dentist, hygienist, and/or assistant will speak with you to outline the treatment performed and necessary follow-up, if any. During the appointment, your child will be supervised **at all times** by a member of our staff. They will be encouraged to play at the Lego table, read a book, play with puzzles and games, play video games or watch TV. We want their time in our office to be remembered as a **FUN** time!
- We understand that there will be times when you will not be able to keep the appointment time that has been reserved specifically for your child. As a courtesy to the other children needing dental attention, **we request that you notify our office at least 24 hours in advance if you will be unable to keep your scheduled appointment time.** Appointments cancelled with less than 24 hours notice will be considered a broken appointment. For your convenience, an answering machine is maintained to allow you to leave a message after our regular office hours. Please feel free to call our office anytime, 24 hours a day! Please note that we reserve the right to dismiss your child from our practice for continued failure to keep scheduled appointments.

MEDICAID RECIPIENTS

- Dentaquest and MCNA policy requires that the dental provider your child will be seeing, be listed as their main dental provider through Medicaid. If our doctor is **NOT** listed as your child's current dentist, and you are unable to have this changed in adequate time prior to your child's dental appointment, it may be necessary for your child's appointment to be rescheduled.

PERMISSION FOR TREATMENT

- We request that parent/legal guardian bring the patient to his/her first visit so they can complete and sign the necessary forms and allow us to more specifically describe your child(ren)'s treatment needs or answer any specific questions you may have. A consent form will be required prior to any treatment. **In order to accommodate our patient families' busy schedules, you may assign others to authorize decisions about your child(ren)'s treatment. Please make sure you sign the Authorization for Treatment of a Minor form so that others you have specifically designated may make decisions about your child(ren)'s treatment.**
- Please note that only those people authorized on the form can make decisions regarding your child(ren).

I acknowledge that I have read and accept the above office policies of Pediatric Dental Specialists, P. A.

Parent/Legal Guardian Signature ____ **Date** ________________

Form 9-Rev.10/13

2921 N. FM 1417 (Heritage Parkway) Suite 100 Sherman, TX 75092 (903) 892-1200 800-362-9078 fax: (903) 813-1581
www.shermankidsdentists.com

FINANCIAL POLICY

Welcome to our practice. Our office is committed to the overall health and well-being of children and their families, with a special emphasis on dental health and education. The following is designed to prepare and inform you of our policies regarding payment and insurance.

- Payment in full is due at the time of service. If the patient is covered by dental insurance, your estimated portion is due at the time of service. We gladly accept cash, check, ATM/debit cards, and major credit cards (VISA, MasterCard, Discover and American Express). We also accept CareCredit, a credit card that offers interest-free financing. If you are interested in applying for this card, please ask one of our office personnel for details.
- Pediatric Dental Specialists does not get involved in disputes between divorced parents regarding financial responsibility for their child's dental expenses. By signing as guarantor below, you agree to be financially responsible for the care we provide to your child, regardless of whether a divorce decree or other arrangement places that obligation on the child's other parent.
- We gladly verify benefits and file claims as a courtesy. It is our goal to help you receive the maximum benefits available under your dental insurance policy. We request you read and understand your dental plan benefits prior to seeking treatment. Please realize that the contract is between you, (the insured), and the insurance company. The amount of coverage you will receive will depend on the quality of the plan purchased by your employer, not the fees of the doctor. Also understand that as a dental care provider, our relationship is with you, not with the insurance company. This means you will be 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. Any balance remaining after insurance payment must be paid within 30 days of billing.
- If an insurance claim is not paid within 30 days, we request that you call the insurance company to see if it is being processed. If they have not received the claim, please get a fax number for us to re-file it.
- We do not accept medical insurance. If a procedure is deemed medical, we require payment in full at the time of service. We will provide a receipt with procedure codes for you to send to your medical insurance.
- Any unpaid balances over 60 days will be assessed a finance charge of 18% A.P.R., regardless of pending insurance claims. Any balances left unpaid over 90 days will be sent to small claims court and will be assessed a collection fee of $65.00 plus any other costs/fees incurred while attempting to collect the debt. All accounts sent to small claims court will be dismissed from the practice.
- If your child requires any type of appliance, we will collect half of the fee at the time impression(s) are taken and the balance when the appliance is delivered.
- There will be a $30.00 service charge for all insufficient checks that are returned.
- Please call our office immediately if you receive a statement for a balance that is in question.
- For accounts with credits, refunds are issued one time each month.

AUTHORIZATION

- I Authorize Pediatric Dental Specialists, PA to release any information concerning my case to my insurance company.
- I have read & accept the above Financial Policy, understand it & agree to the terms set forth regarding payment.

Signature of Parent and/or Legal Guardian	Print: Parent and/or Legal Guardian	Print: Date

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