Pediatric DENTAL SPECIALISTS, P.A.
CREATING SOMETHING TO SMILE ABOUT!

At Pediatric Dental Specialists, we respect your time and make every effort to minimize your wait as we provide quality dental care. As a result, appointment times are reserved exclusively for your child. No shows and late arrivals create delays in treatment for all patients.

Effective January 1, 2020, there will be a $40 fee for failure to provide 24 hours' notice of cancellations. If you present to the office late for a scheduled appointment, we reserve the right to assess a $20 fee and reschedule your appointment as needed.

If Medicaid benefits apply, the patient/family may be dismissed from the practice.

Please contact our office as soon as possible with any changes in your child's health prior to their appointment to discuss the potential need for rescheduling.

Thank you in advance for helping us to ensure the most successful appointments possible!

By signing, I acknowledge that I received information about this policy.

_____ _____

Parent/Guardian/Authorized Party Signature Date (Form 46)

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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? _____

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

Medical History

MUST BE COMPLETED BY PARENT, LEGAL GUARDIAN, OR AUTHORIZED ADULT IF CHILD IS UNDER 18

Patient Name: _____ **Age:**_____ **Date of Birth:**_____ **Gender: M F**

Pediatrician/Primary Care Provider: _____ **Phone Number:**_____

Medical Specialist(s): _____ **Phone Number:** _____

Orthodontist: _____ **Date of last visit:**_____

Immunizations up to date: ☐ **No** ☐ **Yes** ☐ **Do not immunize**

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

Y	N		Y	N		Y	N	
☐	☐	Heart Murmur / Heart Problems	☐	☐	Asthma (Last Attack_____)	☐	☐	Autism / ASD
☐	☐	Allergy to LATEX	☐	☐	Cystic Fibrosis	☐	☐	Physical Impairments
☐	☐	Allergy to DYES	☐	☐	Anemia / Sickle Cell	☐	☐	Learning Disability
☐	☐	Shunt	☐	☐	High Blood Pressure	☐	☐	Developmental Delay
☐	☐	Hemophilia/Bleeding Problems	☐	☐	HIV Positive / AIDS	☐	☐	Behavioral/Personality Disorder
☐	☐	Cancer / Chemo / Radiation	☐	☐	ADD / ADHD	☐	☐	Anxiety/Depression
☐	☐	Organ Transplant _____	☐	☐	Hearing Impairment	☐	☐	MTHFR Deficiency
☐	☐	Kidney Issue / Disease	☐	☐	Acid Reflux / GERD	☐	☐	History of Tuberculosis
☐	☐	Diabetes (Last count_____) Time taken_____)	☐	☐	Convulsions/Seizures/Epilepsy	☐	☐	Dermatologic or Skin Conditions
☐	☐	Liver Issue / Hepatitis	☐	☐	Cerebral Palsy	☐	☐	Sleep Apnea
☐	☐	Digestive / Bladder Issues	☐	☐	Pregnancy	☐	☐	Strong / Excessive Gag Reflex
☐	☐	Anesthesia Issues	☐	☐	Glaucoma	☐	☐	Seasonal Allergies
						☐	☐	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: _____

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 Sign 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

Medical History Reviewed By_____

Time_____ **Age**_____ **Height**_____ **Weight**_____ **BP**_____ **Pulse**_____ **O2 Sat**_____ **ASA**_____ **TX Y N** Form 16/Rev 12/23

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 # _____/_____/_____

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:

Primary Ins. Company_____ Phone #_____ Employer_____ Group #_____

Policyholder's Name _____
Last First Middle

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

Secondary Ins. Company_____ Phone #_____ Employer_____Group #_____

Policyholder's Name _____
Last First Middle

Social Security/ID# _____ Date of Birth _____/_____/_____ Relationship to Patient_____

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 upon receipt of statement. 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 _____

FINANCIAL POLICY

Welcome to our practice! The following are Pediatric Dental Specialists, PA 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.
- 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 or legal guardian.
- We do not accept medical insurance.
- An ESTIMATE for cost of services will be provided prior to treatment based on a clinical and/or radiographic (x-ray) exam. Any unforeseen change in your child's oral condition between the time an estimate is created and the time of treatment can alter the necessary treatment and as a result the amount you may owe, whether you pay with cash or utilize dental insurance.
- For those with dental insurance benefits, please read carefully:
    - The treatment ESTIMATE created is based on information from your insurance company at the time the treatment plan is created. The estimate is based on previous claims history already reported but does not take into account pending claims not yet received or paid by your insurance company. Other dental claims filed or fee updates that occur between the time the estimate is created and the time of service may affect the amount your insurance company will pay, and as a result the amount that will be your responsibility. The estimate is not a guarantee of payment by your insurance company or the exact amount which may be your responsibility. For precise information regarding your insurance coverage for any proposed treatment, we suggest contacting your insurance carrier directly.
    - We gladly file insurance 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, 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 is due in full upon receipt of statement
- Any unpaid balances over 60 days will be assessed a finance charge of 18% A.P.R., regardless of pending insurance claims. Any balances over 90 days will be sent to collections and/or small claims court and will be assessed a collection fee of $100.00 plus any other costs/fees incurred while attempting to collect the debt. All accounts sent to collections and/ or small claims court are subject to dismissal from the practice.
- Insufficient checks that are returned will be assessed the maximum allowable service charge.
- For accounts with credits, refunds are issued one time each month.
- This Financial Policy is subject to amendment without notice. By acceptance of the Financial Policy, you are agreeing to also be subject to any of the Financial Policy amendments. You may receive a copy of our current Financial Policy at any time, upon request.

AUTHORIZATION

- I authorize Pediatric Dental Specialists, PA to release any information to my insurance company as needed for payment of claims.
- I have read, understand, and accept the terms regarding payment of the above Financial Policy.

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

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 24-Rev.10.19

Pediatric
DENTAL SPECIALISTS, P.A.
CREATING SOMETHING TO SMILE ABOUT!

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)

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

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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 guardian / parent : If no one please write N/A.

_____ _____
(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.