

Welcome

Health History Form



For your convenience... Print this form, complete all information, and bring it with you on your first visit to our office. The parent or Guardian who accompanies the child is responsible for payment at the time of service.

1. Tell Us About Your Child

Child's Name _____
Last First MI

Nickname _____ Male Female

Siblings that we treat _____

Child's Birthdate ____/____/____ Child's Age _____

Child's Home # (_____) _____

Child's Home Address: _____

City _____ State _____ Zip _____

2. Mother's Information

Name _____

Stepmother Guardian Birthdate ____/____/____

Marital Status Single Married Separated
 Widowed Divorced

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

3. Father's Information

Name _____

Stepfather Guardian Birthdate ____/____/____

Marital Status Single Married Separated
 Widowed Divorced

Employer _____

Work # (_____) _____ Ext. _____

Home # (_____) _____

Cellular Phone # (_____) _____

SS # _____ DL# _____

4. Who is Accompanying the Child Today?

Name _____

Relationship _____

Do you have legal custody of this child? Yes No

5. Referral

Who may we thank for referring you to our office? Please circle
Website Friend

Dr. _____

Other _____

6. Person Responsible for Account

Name _____

Relationship _____

Billing Address _____

City _____ State _____ Zip _____

Home # (_____) _____

Work # (_____) _____

E-mail _____

7. Primary Dental Insurance

Insurance Co. Name _____

Insurance Co. Address _____

Insurance Co. Phone # (_____) _____

Group # (Plan, Local, or Policy #) _____

Policy Owner's Name _____

Relationship to Patient _____

Policy Owner's Birthdate ____/____/____

Social Security # _____

Policy Owner's Employer _____

8. Dental History

Is this your child's first visit to the dentist? _____

If not, how long since the last visit to the dentist? _____

Date last x-rays taken? _____

Have there been any injuries to the teeth, face or mouth? _____

Has your child had an unhappy experience at the dentist?

If yes, please explain _____

What procedures has your child had?

Laughing Gas **Y N** Numbing **Y N**

Why did you bring the child to the dentist today? _____

Does the child have any of the following habits?

Y N Lip Sucking / Biting **Y N** Nail Biting

Y N Bottle / Sippy Cup **Y N** Thumb / Finger Sucking

Y N Pacifier **Y N** Chewing Objects/Grinding

Has the child ever had a serious or difficult problem associated

with previous dental work? **Yes No**

If yes, please explain _____

Does child drink tap water? **Yes No**

Is the child using fluoride rinses? **Yes No**

Has the child ever had any pain or tenderness in his/her jaw/

joint? (TMJ/TMD)? **Yes No**

Does the child brush his/her teeth daily? **Yes No**

9. Health History

Has the child ever had any of the following conditions?

- | | |
|-------------------------------------|---------------------------------------|
| Y N Abnormal Bleeding | Y N Handicaps/Disabilities |
| Y N Allergies to any Drugs | Y N Hearing Impairment |
| Y N Tuberculosis | Y N Sight Impairment |
| Y N Diabetes / Endocrine | Y N Heart Disease / Murmur |
| Y N Any Operations / Surgery | Y N Hemophilia/Blood disorder |
| Y N Asthma | Y N Hepatitis |
| Y N Cancer | Y N HIV + / AIDS |
| Y N Congenital Birth Defects | Y N Kidney/Liver Conditions |
| Y N Convulsions/Epilepsy | Y N Rheumatic/Scarlet Fever |
| Y N Pregnancy | Y N Allergies to Latex Product |
| Y N Seizures/Fainting | Y N Sickle Cell Trait/Disease |
| Y N Developmental Delays | Y N Current w/ Immunizations? |

Please discuss any serious medical conditions the child has had

Please list all drugs the child is currently taking _____

Please list all drugs the child is allergic to _____

Child's Physician _____

Phone (_____) _____

Is the child currently under the care of a physician? **Yes No**

Please describe the child's current physical health...

Good Fair Poor

10.

Authorization and Release:

I certify that I have read and understand the above information to the best of my knowledge. The above questions have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is also my responsibility to inform this office of any changes in my child's medical status. I authorize the dentist to release any information including the diagnosis and the records of any treatment or examination rendered to my child during the period of such Dental care to third party payors and/or health practitioners. I authorize and request my insurance company to pay directly to the dentist insurance benefits otherwise payable to me. I understand that my dental insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents. I also authorize the dental staff to perform the necessary dental service my child may need. This consent shall remain in full force and effect until cancelled by either party.

Signature of Parent or Guardian

Date

The Parent or Guardian who accompanies the child is responsible for payment at the time of service unless prior arrangements have been approved.

GARLAND PEDIATRIC DENTISTRY

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE
OF PRIVACY PRACTICES**

☼ You May Refuse to Sign This Acknowledgement

_____, have received a copy of this office's
Notice of Privacy Practices.

Please Print Name

Signature

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
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

- _____

- "I acknowledge that I have received and /or been offered a copy of the Dental Materials Fact Sheet as required by law. A copy can be downloaded from the practice web site or I may request one at anytime in the future."
 - "I hereby acknowledge that I have been given the right to review this office's Notice of Privacy Practices."(HIPAA)
 - "I certify that I have read and understand the above. I affirm that the information contained in this form and any additional information that I may furnish is true and correct to the best of my knowledge. I understand the above information is necessary to provide me with dental care in a safe and efficient manner. I will not hold Dr. Grace E. Smart, DDS, MS, or the staff responsible for errors or omissions that I have made in the completion of this form."

GARLAND PEDIATRIC DENTISTRY
GRACE E. SMART, D.D.S.,M.S.
2426 BELTLINE ROAD
GARLAND, TX 75044
972-530-3898

FINANCIAL POLICIES

PAYMENT

All services are payable in full at the time they are provided.
We accept cash, personal checks and credit cards: Visa, Master Card,
American Express, Discover and Care Credit.
Past due accounts over 60 days will be subject to a late fee charge.
A \$30.00 charge will be applied to your account for checks
returned unpaid for any reason.

DENTAL INSURANCE

We will accept insurance assignment as PARTIAL PAYMENT on the
account.
Your deductible and the estimated portion not covered by your insurance are due
at the time services are provided.

We are willing to file your claims with your principal insurance company, but
need your cooperation. We must have a completed and signed insurance form, at
least once a year.

If payment from your insurance company is not received within 45 days from the
date the claim is submitted, you will have to pay the balance and follow-up with
the insurance company.

APPOINTMENTS

Cancellations should be made at least 24 hours in advance in order to give the
appointment time to another patient.
If an appointment is not kept, you will be subject to a \$50.00 charge.

Thank you for giving us the opportunity to provide dental care for your child.

I have read the above policies and agree to comply with them.

Signature _____ Date _____

DENTAL CARE PLANS

WHAT IS DENTAL INSURANCE / BENEFITS ?

Dental insurance is a highly complex topic that creates confusion for many dental patients. The complexities of dental insurance and the lack of sufficient information make it almost impossible for some patients to understand their benefits.

Dental insurance is a **contract** between your **employer** and a **dental insurance company**. The **benefits** that you will receive are based on the terms of the contract that were negotiated between your employer and the dental insurance company and not your dental office. The goal of most dental insurance policies is to provide only basic care for specific dental services. Dental insurance companies **rarely cover 100 percent** of any dental fee and, in many cases, cover less than 50 percent or nothing at all.

Another fact that most dental patients do not realize is that each dental insurance plan has a dollar amount limitation each year. Once this limit is reached, no other services will be covered by your dental insurance company regardless of how essential the service is to your child's dental health until the coverage year starts over.

Some dental plans may limit your right to choose a dentist for your child, or your right to choose a pediatric dentist without first being referred by a general dentist, or your right to choose a pediatric dentist under any circumstance.

You have the right to choose a pediatric dentist for your child.

Pediatric dentists are primary care providers, as recognized by the American Dental Association. Pediatric dentists are uniquely qualified by training and experience to provide the most appropriate, cost effective dental care for children.

Pediatric dental care typically does not cost more than care provided by a general dentist.

Anytime you have questions about your dental insurance, please feel free to ask us. Our office remains dedicated to providing optimal care for every patient and working with you to achieve that goal. We pride ourselves in providing the quality of care to which you have become accustomed. Please let us know if you have any questions. It will be our pleasure to help you.

Please note that we are an out of network provider.

Please be aware that there may be additional out of pocket expenses.

Name _____ Date _____