Attendance Policy – 2017 Updated Policy

We are aware of school policies that make it difficult for children to be out of school for any reason. However, please remind the schools that medical and dental appointments are excused absences.

- The office attempts to schedule appointments at your convenience and when time is available.
- Children under age 6 should be seen in the morning when they are well rested, refreshed and more cooperative. In the afternoon, children are often tired and cranky, which puts us and your child at a disadvantage from the start.
- School children with extensive multiple dental visits needed should be seen in the morning for the same reason.
- Arriving 15 minutes late or more for any appointment may require rescheduling so other patients are not kept waiting. This is considered a broken appointment.

Since appointment times are reserved exclusively for each patient, we ask that you please notify our office 24 hours in advance of your scheduled appointment time if you are unable to keep it. ***During peak office times/high demand days (HD) (days when school is out- MLK, President's day, Spring Break, Columbus Day, Thanksgiving week, Christmas holidays, etc), we require 48 hour notice. If a high demand (HD) appointment is broken in less than 48 hours, we will only be able to reschedule your child on a non HD day.*** Other patients who need our care could be scheduled if we have sufficient time to notify them. We realize that unexpected things can happen, but we ask for your assistance in this regard.

We try to accommodate families by scheduling multiple children together. However, if you no show or cancel under 24 hours we will have to schedule multiple children on separate days.

If for any reason you fail to come or cancel an after-school appointment (2pm or later during the school year) the missed appointment will be rescheduled during school time. This is due to a high demand for after school appointments.

We reserve the right to charge a missed appointment fee of **$35 per child** for excessive broken or missed appointments. Please remember that broken appointments affect many people, not just you.

We make every effort to maintain our appointment schedule and generally do. Occasionally, we treat emergencies (such as traumatic injuries) that demand immediate attention. Please understand that you would wish us to treat your child immediately in a similar situation.

Print Name: ____

Signature: ____

Relationship to patient: _________________________________ Date: ________________

PATIENT INFORMATION

Date: ______/______/______ How did you hear about our office? ____

Patient Name (Last, First, Middle):________________________________ Preferred name: _______________________

Gender: M F Age: _________ Birthdate: ______/______/______ Home Phone: ______________________________

Address: _____________________________________ City: ___________________________ Zip: ______________

Who is accompanying your child today? ____

Relation to the child: ______________________________________ Do you have legal custody of the child? Yes No

In case of emergency, who should we contact? _______________________________ Phone: ____________________

Child's pediatrician's name: ____ Phone: ____________________

What school does your child attend? ____

GUARDIAN INFORMATION (Both Parent/Guardian information required)

Your Name (Last, First) __________________________

Date of Birth: _______/_______/_______

Single Married Widowed Separated Divorced

SS#: _______/______/_______

Address: _____________________________________

City: __________________ State: ____ Zip: _________

Home Phone: _________________________________

Cell Phone: __________________________________

Occupation: __________________________________

Employer: ____________________________________

Email: _______________________________________

Your Name (Last, First) __________________________

Date of Birth: _______/_______/_______

Single Married Widowed Separated Divorced

SS#: _______/______/_______

Address: _____________________________________

City: __________________ State: ____ Zip: _________

Home Phone: _________________________________

Cell Phone: __________________________________

Occupation: __________________________________

Employer: ____________________________________

Email: _______________________________________

INSURANCE INFORMATION

Name of adult who has insurance for the child: _________________________________ Date of Birth: _____/_____/_____

Employer: ____________________________ Insurance Company: _____________________ ID #: _________________

Group #: ______________________________ Insurance Company phone number: ______________________________

DENTAL/MEDICAL HISTORY

Patient name: ____________________________

Is this your child's first dental visit? Yes No If no, when and where was previous visit? ___________________________
Has your child ever had problems receiving dental care? ____
____
Is there a particular problem with your child's teeth that prompted you to bring him/her to our office? _________________
____
Has there been any injury to the teeth, face or mouth? Yes No If yes, describe: __________________________________
____

Does your child brush his/her teeth at home? (Check all that apply)

Yes No Morning Nighttime Parent helps brush Brushes without help Flosses

What type of toothbrush? Manual Electric Other Uses mouthwash (If yes, what brand: ____________________)

What kind of toothpaste: Baby (Safe to swallow) Toothpaste w/Fluoride I don't know Brand: ____________________

Does your child have a <u>history</u> of any of the following habits?

Nursing (Age discontinued ________/Still ongoing)
Bottle (Age discontinued ________/Still ongoing)
Pacifier (Age discontinued ________/Still ongoing)
Snoring (Age discontinued ________/Still ongoing)
Thumb sucking (Age discontinued ________/Still ongoing)
Finger sucking (Age discontinued ________/Still ongoing)
Mouth breathing (Age discontinued ________/Still ongoing)
Grinding teeth (Age discontinued ________/Still ongoing)

Has your child ever had any of the following diseases or medical problems? If yes, please check all that apply:

Congenital heart defect/disease
Heart murmur
Rheumatic fever
Cancer
Diabetes
Liver problems
Hepatitis
Kidney problems
Joint replacement
Excessive bleeding (Hemophilia)
Cleft lip/palate

Epilepsy/seizures
Psychological disorders
Nervous system disorders
Autism
Cerebral palsy
HIV/AIDS
Tuberculosis
Lung problems
Asthma
Sinus/seasonal allergies
Premature: YES NO Born at _______Weeks

Eye problems
Hearing problems
Food, metal, dye allergies ________________
Speech problem/delay
Developmental delay
Sensory disorder/PDD
ADD/ADHD
Overnight hospital stays _________________
Operations______________________________
Pregnancy

Other: ____

Is your child allergic to any medications, anesthetic, or latex? Yes No If yes, please list: __________________________
____

Is your child taking any medications? Yes No If yes, please list: ______________________________________
____

Does your child need antibiotic treatment prior to dental appointment? Yes No
Is your child in good health? Yes No
Is your child up to date on all immunizations? Yes No
Is there anything else you would like us to know about your child that can help us treat his/her needs better? __________
____
____

I understand that the information I have given is correct to the best of my knowledge, that it will be held in the strictest of confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I authorize the dental staff to perform the necessary dental services my child may need.

____
Signature Printed name of parent/guardian Date

For office use only:
ROS: ____
Meds: ____
OR/Hosp: ____
ALL: ____
I verbally interviewed the medical/dental information above with the parent/guardian and patient name herein. Initials: ___________Date_____________

Arlington Pediatric Dentistry

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

****You May Refuse to Sign This Acknowledgement****

I have received a copy of this office's Notice of Privacy Practices.
(Please ask the front desk if you would like a copy.)

____
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) ____

HEALTH INFORMATION ACCESS
ARLINGTON PEDIATRIC DENTISTRY

The following are names of people, including myself, that I would like to be involved in or have access to my child's protected health information. I give permission for Arlington Pediatric Dentistry to share my child's protected health information with:

Name of person filling out paperwork	Relationship to children	DL# or SS#
Name	Relationship to children	DL# or SS#
Name	Relationship to children	DL# or SS#
Name	Relationship to children	DL# or SS#

If you wish to add or terminate information access to or from the above list, you must submit your request in writing to:

ATTN: Shasta
Arlington Pediatric Dentistry
7410 South Cooper Street, Suite 100
Arlington, TX 76001

You may also fax your request to 817.465.0055 or email to info@arlingtonkidsdentist.com
Please sign and date your request

Financial Policies, Arrangements and Conditions

Welcome to our practice! We are pleased that you have selected our office for your child's dental care and we value the confidence you have expressed in choosing Arlington Pediatric Dentistry. We understand that parents are concerned not only with the quality of their children's dental care, but also with the costs of professional services. Therefore, we have outlined below the financial policies of this office.

- Payment is expected the day service is rendered. This includes co-payments and deductibles. We accept cash, checks and credit cards (VISA, MasterCard, and Discover). **There will be a $35.00 service charge for all returned checks.**
- If you carry dental insurance, please present your current insurance card the day of your child's appointment. If insurance coverage cannot be verified, you will be responsible for payment of all fees and we will provide you with a claim form for you to submit for reimbursement.
- Since there are many different insurance plans available, we recommend that you contact your employer or insurance representative to obtain details regarding your benefits and eligibility.
- If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and estimated copayments at the time of service. You are responsible for paying all charges not covered by your insurance company, including all fees considered above our insurance company's usual and customary fee schedule. Any remaining balances will be billed to you after a claim is paid. Your insurance benefits are contracted between you and your employer. The amount of coverage you will receive will depend on the type of plan purchased by your employer and is not related to our professional fees.
- The office cannot carry insurance balances longer than 60 days. If the insurance carrier does not pay a claim, you are responsible for the balance in full. Our office will make every reasonable effort to obtain payment from your insurance company. Any additional insurance appeals will become your responsibility. We will be happy to provide you with any necessary forms or receipts. Delinquent accounts may be subject to a monthly finance charge.
- **The parent or guardian who brings the child for treatment is the responsible party. This parent is required to pay for services rendered regardless of what a divorce decree may state.**

I certify that my child is covered under ___________________________________ insurance and I assign appropriate insurance benefits directly to Arlington Pediatric Dentistry.

I understand that I am responsible for any remaining balance not covered by my insurance, and hereby authorize Arlington Pediatric Dentistry to release all information necessary to secure payment for dental services rendered. I authorize the use of this signature on all my insurance submissions whether electronic or manual.

Please be aware that your insurance may or may not cover the fluoride or x-rays recommended. If the insurance company denies payment, you will be responsible for the balance.

I have read and fully understand the financial policy of this office and have received a copy. I agree to the terms set forth regarding payment.

____

Parent/Guardian Signature Print Name Date