Coppell
PEDIATRIC DENTISTRY

Welcome to our office

Patient's Name_____**NickName**_____**Age**_____

Sex_____ **D.O.B.**_____**School Attending**_____

Patient's Address_____**Home Phone**_____

Street_____ **City** _____**State**_____**Zip**_____

Parent/Guardian #1_____**DOB**_____**Social Security#**_____

Home Phone_____**Cell Phone**_____

Street_____ **City** _____**State**_____ **Zip**_____

Where Employed_____**Work Phone**_____

Employer's Address_____

Dental Insurance_____

Insurance Policy Number_____ **Group number**_____

Medical Insurance_____

Insurance Policy Number_____ **Group Number**_____

Parent/Guardian #2_____**DOB**_____**Social Security#**_____

Home Phone_____**Cell Phone**_____

Street_____ **City** _____**State**_____**Zip**_____

Where Employed_____**Work Phone**_____

Employer's Address_____

Dental Insurance_____

Insurance Policy Number_____ **Group number**_____

Medical Insurance_____

Insurance Policy Number_____ **Group Number**_____

Medicaid Information…

Type of Medicaid _____

Member ID/ Subscriber #: _____

Emergency contact information…

Whom may we notify in case of an emergency? _____

Relationship to patient: _____

Best contact number: _____

Medical History

Please answer the following questions so that we may provide optimum care for you…

Is your child currently under the care of a medical doctor? _____

If so, please provide the Doctors name and reason for care: _____

_____

Is your child currently taking any prescription drugs? Please list: _____

Does your child have any allergies? Please list: _____

Does your child have any behavioral issues (ADHD, AUTISM, etc.)?_____

Has your child had any major surgeries in the last five years? _____ Please list date: _____

Does your child have pins, plates, screws, or artificial joints? _____

Have you ever been informed of your child having a heart murmur, condition, or had heart surgery? Please explain in detail:

_____

Has your child ever bled excessively? _____ Has your child ever had complications with anesthesia? _____

Has a previous dentist ever used Nitrous Oxide (laughing gas) in dental treatment? _____

Please circle any of the following and provide a date if your child has had or currently has:

High/low blood pressure:	Rheumatic Fever:	Glaucoma (wide or narrow?):	X-ray or Cobalt Treatment:	
Tuberculosis:	Chemotherapy:	Mitrovalve Prolapse:	Liver Disease:	HIV:
AIDS:	Hepatitis A, B, or C:	Chest pain:	Yellow Jaundice:	Anemia:
Blood Transfusion:	Hemophilia:	Sickle Cell Disease:	Kidney Trouble:	Stroke:
Congenital Heart Lesions:	Scarlet Fever:	Hay Fever:	Narcotic addiction:	Hives:
Sinus Trouble:	Asthma:	Ulcers: Cold Sores:	Arthritis:	
Rheumatism:	Cortisone Meds:	Psychiatric Treatment:	Drug Addictions:	Epilepsy:
Fainting:	Nervousness:	Eating Disorder:	Diabetes:	
Thyroid Disease:				

Is there anything that has not been covered on this form that you would like to share with us regarding your child's overall dental history? _____

The information I have given today is true and correct to the best of my knowledge. I will inform the doctor/assistant/hygienist if there is any change in my child's medical or dental status.

_____

Parent or Guardian Signature: Date:

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Dental History

Please answer the following questions so that we may provide optimum care for your child…

Reason for today's visit: _____

How long has it been since your child's last dental visit? _____ Were dental x-rays taken? _____

Previous Dentist's name: _____ Previous Dentist's phone number: _____

Was there any recommended dental treatment not completed? _____

Does your child feel nervous about having treatment? Yes No

Has your child ever had an unpleasant experience at a dental office? Yes No

Have you ever considered braces or other orthodontic treatment for your child? Yes No

Does your child brush and floss daily? (With or without your assistance) Yes No

In general, how do you feel about your child's overall dental health? _____

Is there anything that has not been covered on this form that you would like to share with us regarding your child's overall dental history?

The information I have given today is true and correct to the best of my knowledge. I will inform the doctor/assistant/hygienist if there is any change in my child's medical or dental status.

_____

Parent or Guardian Signature: Date:

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AUTHORIZATION TO TREAT A MINOR

I, as the Parent/Guardian of _____ am legally able to make all medical/dental decisions for said child. I understand that by signing this form, all responsibility, for consenting to proposed and preformed treatment is my decision, and I do not legally need to consult anyone else in order to authorize treatment of my child.

I am authorizing the following person(s) to consent to dental treatment in the event I cannot attend a dental appointment.

_____ _____

NAME OF AUTHORIZED PERSON RELATIONSHIP

_____ _____

NAME OF AUTHORIZED PERSON RELATIONSHIP

_____ _____

PARENT/GUARDIAN SIGNATURE **DATE**

Coppell Pediatric Dentistry
Privacy Notice

This notice describes how medical/dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

We understand that the privacy of your personal information is important to you. As your dental office, we believe your right to privacy is a fundamental part of your treatment; as such, we want you to understand our privacy practices and procedures. Should you have any questions regarding these policies please do not hesitate to call the office at (469) 444- 6579

Information We Collect About You

We collect personal information about you and your family as part of our new patient process, during the course of your care, and from other health care entities you utilize such as, other dentists and specialists, imaging facilities, laboratories and your insurance company. This personal information includes items such as your name, address, phone number, birth date, social security number, employer, health history, insurance policy and coverage information, and any information you provide. During the course of your child's treatment we will collect dental information regarding diagnosis, treatment plans, progress and any test results or films.

How Your Information Is Used

The personal and health information gathered may be used and disclosed with your general consent for purposes of treatment, payment, or routine healthcare operations. This means we may send your child's information to other dentists or facilities involved in your treatment as well as to your insurance company or a collection agency to obtain payment. Any other uses of your information require a signed authorization by you, the patient or guardian and can be revoked in at any time with a written request. Coppell Pediatric Dentistry does not sell patient information to marketing or pharmaceutical companies. In certain cases of public health interest we may be required to disclose certain information to local, state or national health organizations or government agencies.

We may contact you to provide appointment reminders or information about treatment. *Safeguarding Your*

Personal and Health Information

We are required by law to (1) make sure that medical information that identifies your child is kept private (2) provide you with our privacy policy (3) follow the terms laid out in the privacy policy. As a means of protecting your privacy, we restrict access to your child's personal and health information to only those employees who require the information to complete their jobs and provide quality service to you.

Coppell Pediatric Dentistry maintains physical, electronic and procedural safeguards to comply with state and federal regulations that guard your child's personal and health information. If you feel your privacy has been violated you have the right to file a complaint with the Department of Health and Human Services. The complaint in no way influences your course of treatment with Coppell Pediatric Dentistry.

Changes to Our Privacy Policy

All new patients will review a copy of our privacy policy. Coppell Pediatric Dentistry occasionally reviews its privacy policy and reserves the right to amend it. Notification of changes will be available at the front desk prior to the effective date of any changes.

Your Right to Restrict Use of Information

You have the right to request restrictions to our uses or disclosures of your child's personal or health information, although we are not required to agree to those restrictions. Once your request has been processed it will remain in effect until you request a change.

Patient (or Parent/Guardian) Acknowledgement

I_____have reviewed Coppell Pediatric Dentistry's Privacy Policy.

Parent/Guardian Signature _____Date_____

Coppell
PEDIATRIC DENTISTRY

OFFICE POLICY AND CONSENT FORM

Please remember that we are here to serve your family in a comfortable and professional atmosphere. Our goal is to provide your family with the very best quality of dental care.

INSURANCE AND PAYMENT POLICIES

- **FEES FOR SERVICE AT OUR OFFICE WILL BE REQUESTED AT THE TIME OF YOUR VISIT.** For treatment involving fees above $500.00, special financial arrangements may be discussed with our office manager.

- For patients with Dental Insurance:

  We will file your claim for you at *no charge*, however, we ask that your deductibles and your estimated portions (20-60%) be paid as services are rendered. Although we gladly file dental insurance claims, any and all account balances are ultimately your responsibility.

  All insurance benefits are assigned to the Doctor, unless services are paid in full the day of treatment.

- Please note for your convenience, we do accept VISA, MasterCard, Discover, and Care Credit as well as checks and cash.

OFFICE POLICIES

- Your appointment time is set aside especially for your child. We ask for courtesy to the Doctor and to other patients that you keep your scheduled appointments. **If you must change or miss an appointment, we would require a 48-hour notice.** Repeated cancellations or failures will result in a broken appointment charge or no reappointment.

- We realize that many families are in a state of change. **The policy in our office is that the parent who requests treatment for a child is responsible to us for all fees incurred.**

- We will be fair in working out special finances with you, but please also be fair to us with your commitments. ***A 1.5% finance charge will be assessed monthly on all overdue balances.***

CONSENT:

I have read and understand all the above information. The undersigned hereby authorizes the Doctor to perform those diagnostic and treatment procedures, including local anesthesia and sedation, deemed necessary. If I ever have any change in my child's health or change in their medication, I will inform the Doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the Doctor and authorizes the release of dental records to my insurance company.

Date _____ Parent/Guardian Signature _____

Coppell
PEDIATRIC DENTISTRY

Notice and Consent Form

Patient Name:_____

Parent's Name:_____

Coppell Pediatric Dentistry wants you and your child's visit to be both educational and enjoyable. Therefore, we request that you read this **Consent and Notice Form** carefully.

This form is meant to provide information on some of the routine procedures we perform. If you do not have any questions or concerns we ask that you complete the form and sign the bottom of the page giving us your consent to perform the listed procedures if deemed necessary.

Please place a √ next to each box indicating that you understand and consent to the procedure:

☐ Consent to receive dental treatment: I consent and authorize Dr. Coe and her employees to examine, clean, and provide dental treatment for my child. I further consent and authorize the taking of dental x-rays, as may be considered necessary, by Dr. Coe to diagnose and/or treat my child. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes.

☐ Consent to receive Nitrous Oxide/Oxygen Sedation: I consent and authorize Dr. Coe to use, if deemed necessary, Nitrous Oxide (laughing gas) during the treatment of my child. Nitrous oxide/oxygen sedation is a generally safe and effective technique to reduce or eliminate anxiety and enhance effective communication. Its onset is rapid. The depth of sedation is easily titrated and reversible, and recovery is rapid and complete.
Additionally, nitrous oxide aids in analgesia (reducing pain) and reducing the gag reflex.

Date:_____ Parent/Guardian's Signature: _____