Lewisville Kids Dentistry

501 S. Stemmons Freeway
(972)436-9121
www.lewisvillekidsdentistry.com

Tell us about your Child:

Child's Name: _____

Preferred Name:_____

Birthday: _____Age: _____ Male | Female

Child's Home Address:
_____

City: _____State____Zip:_____

Patient's School:
_____ Grade: _____

Who is accompanying the child today?

Name: _____Relation:_____

Do you have custody of this child? YES / NO

Parent's Marital Status: _____

Other Family Members Seen By Us:

_____

_____

Mother's Information: Step-Mom / Guardian

Name:_____

DOB:_____ SS#:_____

Home #_____ Cell# _____

E-mail: _____

Father's Information: Step-Father / Guardian

Name:_____

DOB:_____ SS#:_____

Home #_____ Cell # _____

E-mail: _____

Person Responsible for Account:

Name: _____ Relation: _____

Billing Address:_____

City: _____State:_____ Zip: _____

SS#:_____DL#_____

Dental Insurance:

Insured Employer:_____

Policy Holder's Name: _____

SS# or ID#:_____ DOB:_____

Insurance Company: _____

Relationship to Patient: _____

How did you hear about us?

Internet | Mail | School | Family comes here

Doctor's Office:_____

Friend: _____

Other:_____

Appointments:

How may our office contact you in the future?

(Please check all that apply and provide information)

- o Phone:_____
- o Text:_____
- o E-mail: _____

Reason for Today's Visit: _____

Health History:

Patient's Physician's Name:_____ Phone #_____

YES NO Is your child allergic to anything? If YES, _____

YES NO Has your child ever been hospitalized? Please give reason and dates: _____

YES NO Is your child currently taking any medications? If YES, please list and give reason: _____

_____

Please Check, if your child has been treated for any of the following:

□ Heart disease	□ Bleeding/transfusions	□ Asthma	□ ADD/ADHD
□ Liver/GI disease	□ Anemia	□ Diabetes	□ AIDS/HIV
□ Kidney disease	□ Rheumatic fever	□ Hepatitis (A/B/C)	□ Mental delays
□ Speech/hearing	□ Seizures	□ Cleft lip/palate	□ Physical delays
□ Cerebral Palsy	□ Congenital Birth Defects	□ Personality/social	□ Other
□ Cancer/tumors	□ Recurrent headaches	□ Frequent Infections	

Please elaborate if any were checked:_____

_____

Please list any conditions not listed above: _____

Dental History

YES NO Has your child ever been to the dentist? If yes please complete below:

Doctor or Office's Name:_____ Phone:_____ City:_____

Date of last dental visit & radiographs:_____

YES NO Has your child experienced any unfavorable reaction from previous dental visit? If yes, please elaborate below:

_____

YES NO Does your child suck a finger, thumb, or pacifier?

Please Check, if your child is having problems with any of the following:

□ Cavities □ Toothache □ Sensitive Teeth □ Trauma: _____ □Gum Infections □ Color of teeth

Consent for Dental Treatment

I request and authorize Dr. Clapp and Associates to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays considered necessary by Dr. Clapp and Associates to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic, educational and in office promotion purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Clapp, and Associates will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature: _____ **Date**: _____

Lewisville Kids Dentistry

Parental Agreement / Office Policies

Parents are welcome to accompany their child into the treatment area during the initial examination. This gives you the opportunity to see our dental team in action and allows the doctors to discuss dental findings and treatment needs directly with you. We do ask that if you accompany your child you assume the role of a silent observer. Your presence is greatly enhanced if you play a passive role. If more than one person is speaking to the child they may become confused. Cooperation and trust must be established directly between the doctors and staff and your child, not through you. We also ask that siblings remain in the reception room or play area. There may be times when a child's experience is enhanced by a parent's absence. We encourage children to come back to the treatment area by themselves, as this builds autonomy and trust. After your child's first visit your child will come to the treatment area by themselves, unless specific arrangements have been made in advance. Children who are very apprehensive may look for an "escape" by going to their parents – this is why we ask the parents to stay in the waiting room during treatment in order to facilitate a more direct line of communication between the child and the doctor. The following is a brief explanation of some of the methods we use to guide your child's behavior and provide a positive dental experience. Since each child is unique, no list can be complete and other methods may be explained as needed.

Tell, Show, Do: This is the most important tool for teaching your child. The child is told in simple terms what is going to be done. Then they are shown what is going to be done and then the procedure is performed.

Imagery: We tell children in simple terms what is going to be done. For example, a dental exam becomes "looking and counting teeth". A dental prophylaxis and cleaning becomes "brush and tickle your teeth". We encourage you to use these terms when talking to your child about their dental experiences.

Distraction: Sometimes it is necessary to distract your child from an unpleasant sensation by focusing his/her thoughts on something other than what is being done.

Positive Reinforcement: This is a technique used to reinforce good behavior by praising your child or providing a reward following a desired respose in hopes of promoting continued good behavior.

Voice Control: Voice Control is a controlled change of voice volume, tone or pace to influence and direct the child's behavior. This technique is used to establish a line of communication between our doctors and your child.

This agreement and these policies are in place to ensure that we can provide the best, most positive dental experience for your child. Please feel free to ask anyone in the office if you have any questions. Thank you for allowing us the opportunity to provide dental care for your child.

I, _____, agree to follow the above policies and agreement.

_____ _____

Signature of Parent / Guardian Date

Child's Name: _____ DOB**:** _____

Parent/Guardian's Name: _____

Welcome to our office!

We are pleased that you have chosen us to take care of your child's dental needs. To make our time together most efficient and enjoyable for you, we have listed our office policies below.

Please read them carefully

1 - Your appointment: Be on time for your appointment. If you are more than 10 minutes late, you risk cancellation.

2 - Failed appointment policy: If a *CONFIMRED* appointment is missed, one last chance will be given before you are put on Same Day stand by status. This means you will no longer be given an appointment. You will be served as a "Walk in" patient.

This is extremely important to us, as we reserve time for each patient – if you are late or do not show up; you are taking time away from our other patients.

3 – Insurance: We gladly work with most insurance, and as a courtesy to our families with insurance we will file your insurance claim. Therefore, it is extremely important that you notify us with any changes with your insurance.
We have no control over what your insurance will reimburse for a particular service; that information varies with each particular policy. We are not told the dollar amount of your copay by the insurance company; therefore it is not possible to give a completely accurate estimate, but we do strive to be as accurate as possible.

4 – Statements: We send monthly statements on all open account balances, so that you are aware of what credits and payments have been made to your account. Unless specific arrangements have been made with our Financial Department, all Accounts over 90 days will be referred to an outside collections agency. Also an additional charge of $50 will be added to your account.

5 – Cancellation: A 48 hour notice must be given for cancellation of any appointment. We contact you 48 hours before your appointment to confirm. Not confirming your appointment may lead to cancellation or rescheduling of your appointment. Please keep us up to date on all current phone numbers to help us reach you for confirmation. Telephone voice mail and email are available 24 hours a day and confirmation may be left on it anytime!

I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered by my insurance carrier. These policies are for the benefit of everyone. If you have any questions, please ask our office staff.

Signature: _____ Date: _____

Lewisville Kids Dentistry

Financial Policy

Thank you for choosing our office for your child's dental care.
Our clinical and administrative staff works closely together to provide a positive environment for visits to our office and assistance with financial requirements. A clear understanding between all of us will help insure that our main concern is with your child's dental care rather than spending excessive time collecting payment from an insurance company.

We would like to encourage payment in full for all services at the time of the visit.
For those with dental insurance, we realize this may not be the preferred choice of payment for your child's dental care. Therefore, as a service to our families we will file your insurance claim. If you would like us to file your insurance claim for you, please provide our office with a copy of your current insurance identification card for each visit. Without this information, we cannot file your insurance for payment to us. With this information, we will file your claim immediately. However, we must be able to confirm with your insurance company that they can assign benefit payments to our office. If an insurance company cannot confirm assignment of benefits, you will be required to pay for all services at the time they are rendered.

We have no control over your dental benefits and the amount of an insurance company reimburses for a particular service that information varies with each particular policy.
We have recently become preferred providers (in – network) for the following companies: Cigna (Radius ONLY)PPO, Guardian PPO, Aetna PPO, and Delta Dental Premier and United Health Care. We are not preferred providers for all other insurance companies (we are considered out of network). In some cases insurance companies use outdated fee schedules or require a larger co-pay or deductible from the family. We are not told the amount of the co-pay by your insurance company; therefore it is not possible to give you a completely accurate estimate. For these reasons, we require you pay 40% of covered services and full payment for non-covered services at each visit to cover the cost of your deductible, co-pays, and non-covered services.

We are happy to help our families who have dental insurance by accepting their insurance. However, please understand that you always have the final responsibility for payment of any services rendered.
We are not responsible for any limitations in coverage that may be included in your plan. For this reason we ask for a credit card number to be kept on file for your account. Your credit card will be billed for any remaining balance after the insurance payment is received. If your insurance company has not responded within 45 days after date of service, you card will be charged. If an insurance payment is received after 45 days a credit will be issued to your credit card. Unless specific arrangements are made with our Financial Department, all accounts with any balance over 60 days will be sent to an outside collection agency. There is a $50 charge to all accounts that go to collections.

Our staff is always available to discuss any questions and assist you.
Your child's dental health depends upon the success of our partnership. Please feel free to ask for our assistance at any time.

I have read and understand my obligations and I acknowledge that I am fully responsible for payment of any services not covered by my insurance carrier.

Patient (s) name (s)

Parent or Legal Guardian Date

I hereby authorize payment of the dental benefits, otherwise payable to me, directly to the above name dental entity.

Signed (Policy Holder)

Credit Card Pre-Authorization

**Please keep this signature on file to cover any unpaid balance after insurance payment is received, for any treatment performed in the office for my child (ren). Also for any type of payment plan as agreed upon.

□ Visa □ MasterCard □ Discover □ American Express

Card # :_____

Exp: _____ CV Code:_____

Cardholder Signature:

_____

No, **I DO NOT AUTHORIZE Lewisville Kid's Dentistry to charge my credit card for balances. I understand that by not leaving a credit card pre-authorization on file, I will be required to PAY IN FULL for all treatment and will be reimbursed directly from my insurance company.

Signature

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement but, in refusing we *will not be allowed* to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for Lewisville Kids Dentistry. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTORS IN THE FUTURE.**

_____
Please ***print your child's*** name

_____ _____
Please ***print*** your name Please ***sign*** your name

_____ _____
Legal Representative Description of Authority

PLEASE LIST ANY OTHER PARTIES WHO CAN HAVE ACCESS TO YOUR CHILD'S DENTAL INFORMATION:
(This includes step parents, grandparents and any care takers who can have access to this patient's records):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I AUTHORIZE CONTACT FROM THIS OFFICE TO **CONFIRM MY DENTAL APPOINTMENTS, TREATMENT & BILLING INFORMATION** VIA:

- ✓ Cell Phone Confirmation
- ✓ Home Phone Confirmation
- ✓ Work Phone Confirmation
- ✓ Text Message to my Cell Phone
- ✓ Email Confirmation
- ✓ U. S. Mail / Postcard

I AUTHORIZE **INFORMATION ABOUT MY DENTAL HEALTH** BE CONVEYED VIA:

- ✓ Message on Cell Phone
- ✓ Message on Home Phone
- ✓ Message on Work Phone
- ✓ Text Message
- ✓ Email Message
- ✓ U. S. Mail / Postcard

I APPROVE BEING CONTACTED ABOUT **SPECIAL SERVICES, EVENTS or NEW DENTAL INFO** via:

- □ Phone Message
- □ Text Message
- □ Email
- □ U. S. Mail / Postcard
- □ **Any of the above**

Office Use Only

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment _____
I could not communicate with the patient _____
The patient refused to sign _____
The patient was unable to sign because _____
Other (please describe) _____

_____
Signature of Privacy Officer