2109 W. University Drive | Denton, Tx.76201

940-484-5437

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: ______

Mother's Information: Step-Mom / Guardian

Name:____

DOB:_____________ SS#:____________________________

Home #___________________ Cell# ___________________

E-mail: ____

Person Responsible for Account:

Name: _________________________ Relation: ___________

Billing Address:_____________________________________

City: ______________________State:______ Zip: _________

SS#:___________________DL#__________________

How did you hear about us?

Internet | Mail | School | Family comes here

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:

____

____

Father's Information: Step-Father / Guardian

Name:_______________________________________

DOB:_______________ SS#:_____________________

Home #________________ Cell # _________________

E-mail: _______________________________________

Dental Insurance:

Insured Employer:______________________________

Policy Holder's Name: __________________________

SS# or ID#:_______________________ DOB:_______

Insurance Company: _____________________________

Relationship to Patient: __________________________

How may our office contact you in the future?

(Please check all that apply and provide information)

Phone:______________________________

Text:_______________________________

Email: _____________________________

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

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**: ___________________

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.

<u>Please read them carefully</u>

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 *CONFIRMED* 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: __________________

Insurance Courtesy Notification

North Texas Pediatric Dentistry & Orthodontics will gladly file your dental insurance as a courtesy. However, please realize that the entire account balance is the obligation of the responsible party.

Please note that all claims are filed electronically to ensure receipt by the insurance company in a timely manner. After 30 days of non-payment, a second claim will be submitted. In addition, your insurance company will be contacted by our office to inquire on the status of the claim.

By signing below, you acknowledge that if your insurance company fails to remit payment after 60 days from the date of service, the entire account balance is due in full by the responsible party.

Responsible Party: _______________________________________ Date: ______________________

PLEASE READ: I understand that the standard of care for a routine six month dental check up and cleaning as prescribed by the ADA and American Academy of Pediatric Dentistry includes, but is not limited to:

- Comprehensive / Periodic Oral Eval (D0150;D0120)
- Prophylaxis (dental cleaning) (D1110;D1120)
- Topical Fluoride Application (D1208)
- Diagnostic X-rays (D0220;D0230;D0272;D0274)

Individual Insurance Plan variables and guidelines may affect coverage and limit benefits for the above procedures. It is the responsibility of each policy holder to be familiar with their particular policy coverage prior to scheduling any visit. X-rays are typically taken once per year, unless otherwise ordered by the Dentist. **Fluoride is applied at EVERY check up and cleaning visit.**

******Please note:**
We are considered "In-Network" for the following companies: Delta Dental Premier PPO, Cigna Radius PPO, Aetna PPO , Humana , BCBS of Texas. All others – we accept, however, we are considered out of network.

Childs Name:____

Responsible Party: ________________________________ Date: ______________________

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. ***North Texas Pediatric Dentistry & Orthodontics will call you prior to running your credit card.

Visa MasterCard Discover American Express

Card # :____

Exp: ______________________________ CV Code:____________

Cardholder Signature:

____

No, **I DO NOT AUTHORIZE North Texas Pediatric Dentistry & Orthodontics 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

____

Parental Agreement

Parents are allowed to accompany their children into the treatment area during the 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 or hygienist and your child. 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. Children who are very apprehensive may look for an "escape" by going to their parents – this is why we ask that a parent wait in the reception 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 your 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 response 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 a question or questions. Thank you for allowing us the opportunity to provide dental care for your child.

Signature_________________________________ **Date**______________________