Patient Information

Patient Name: ______________________________________ Date:__________
First MI Last
Gender:__M / F__ Birthdate: ______________________ Nickname: __________

Child's Favorites (TV shows, Pets, Toy, Friends, Activities, - Conversation Starters) ______________

Phone (Home) : ____

Address____
Street Apartment #

____
City State Zip Code

Health Information

Previous Dentist:______________ Date of Last Dental Visit: ______________ Reason for this visit:__________________

Times a day child brushes? __________ Times a week child flosses? ________ Is your water fluoridated? _________

- How would you rate your child's smile? **Worst** 1 2 3 4 5 6 7 8 9 10 **Best**

- Does the child do any of the following? ☐Thumb/Pacifier/Finger Sucking ☐ Tongue Thrusting/Sucking ☐Grinding ☐Heavy Snoring ☐Mouth Breathing ☐Lip Sucking/ Biting

Does Child have or ever had any of the following diseases, medical conditions or procedures? Please check those that apply: ***(By checking "NONE" you agree that you have read ALL conditions and that NO conditions currently apply to the child)***

☐ Allergies Environmental
☐ Allergic to Medication
☐ Allergies Food/Dye
☐ AIDS /HIV / ARC
☐ Anemia
☐ Autism
☐ Asthma/ Lung problems
☐ ADHD/ADD
☐ Birth Defects ________
☐ Cancer/Tumors
☐ Cerebral Palsy
☐ Diabetes
☐ Difficulty w/Speech
☐ Epilepsy/Seizures
☐ Excessive Bleeding

☐ Cleft Lip/Palate
☐ Hearing Problems
☐ Hyperactivity
☐ Hospitalization/Surgery
☐ Head Injuries
☐ Heart Disease
☐ Heart Murmur
☐ Hepatitis (A,B,C)
☐ High Blood Pressure
☐ Jaundice
☐ Kidney Disease
☐ Liver Disease
☐ Mental Disorders
☐ Nervous Disorders
☐ Mouth Injuries
☐ Latex Allergy

☐ Leukemia
☐ Radiation Treatment
☐ Respiratory Problems
☐ Rheumatic Fever
☐ Rheumatoid Arthritis
☐ Sinus Problems
☐ Stomach Problems
☐ Stroke
☐ Tuberculosis TB
☐ Artificial Bones/Joints
☐ Ulcers
☐ Prolonged Bleeding
☐ Codeine Allergy
☐ Penicillin Allergy

☐ OTHER

Please explain any checked responses

____
____
____
____
____
____
____
____

☐ **NONE**

- Name of Physician: ______________________________________ Telephone Number: ____________

Date of most recent medical examination :______________ Child's Current Weight:____________________

- Does the child require pre-medication for dental visits? ☐ Yes ☐ No ☐ Don't Know

- Is the child currently taking any of the following medications? ☐ Pain Medications (including Aspirin) ☐ ADD/ADHD Meds ☐ Blood Thinners ☐ Tranquilizers ☐ Insulin ☐ Muscle Relaxers ☐ Others: ____________

List all current medications: ____________________ List any allergic reactions to medications: ________________

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If there is ever any change in health (including medications), I will inform Coppell Dentistry for Kids at the next appointment without fail.

____ ***Date:*** ____________________

Signature of patient, parent or guardian

Family Information

Who is accompanying this child today? ____
Do you have LEGAL CUSTODY of this child? ____________Does the child have brothers/sisters? _____ How many? ____________
Names (circle if Coppell Dentistry for Kids Patient)____

Referral Information

Whom may we thank for referring you to our practice? ☐ Another patient, friend ☐ Another patient, relative
☐ Dental Office ☐ Internet / Google ☐ Pediatrician ☐ Magazine ☐ School ☐ Mail Advertisement ☐ Other
Please list the name of person or office referring you to our practice so we may thank them: ________________________

Responsible Party Information

Father's Name: ____________________________________ Mother's Name:_________________________________
☐ Married ☐ Single ☐ Divorced ☐ Other ☐ Married ☐ Single ☐ Divorced ☐ Other

Father's DL#_____________________________ **Mother's DL#**___________________________________

Mother's Phone (Home): __________________________ (Work): ________________________Ext: ____________
Father's Phone (Home): __________________________ (Work): ________________________Ext: ____________
Father's Cell Phone: ____________________________Mother's Cell Phone: ___________________________.

Responsible Party Address: ____
Street Apartment #
____
City State Zip Code

Email Address: ____

Employment Information

Mother's Employer: ___________________________________ Occupation: ______________________________

Father's Employer: ___________________________________ Occupation: ______________________________

Insurance Information

Primary
Name of Insured: ____ Social Security Number:____________________
Last First
Insured's Birth Date: ________________ ID #: ____________________ Group #: ____________ **DL#**_______________
Street City State Zip Code
Insured's Employer Name: ____

Patient's relationship to insured: ☐ Self ☐ Spouse ☐ Child ☐ Other ____________________
Insurance Plan Name & Phone Number: ____
____

Consent for Services

Our policy requires payment in full for all services rendered at the time of visit unless other arrangements have been made with the business manager in advance of the appointment. If account is not paid within 90 days of the date of service and no financial arrangements have been made, you will be responsible for legal fees, collection agency fees, interest charges and any other expenses incurred in collecting your account.

The undersigned is the person who has completed this form and is able to answer the above questions accurately. In addition, the undersigned has legal authority to obtain dental care for the above named child. I hereby authorize any/all dentists associated with Coppell Dentistry for Kids (Louca, Shah, Holt, Lalani and/or other health care providers as deemed necessary,) to provide all necessary dental treatment as diagnosed. Patients who have insurance understand that all dental services are charged directly to the patient and that he or she is personally responsible for payment of all dental services should the insurance company fail to remit payment for the claims in a timely manner. This office will prepare the patients insurance claims or assist in making collections from insurance companies as a courtesy for the patient as long as the account stays in "good standings" with Coppell Dentistry for Kids. This courtesy may be rescinded if the account of the guarantor enters into default at any point.

A service charge of 1½% per month (18% per annum) on the unpaid balance will be charged on all accounts exceeding 60 days, unless previously written financial arrangements are satisfied.

I understand that the fee estimate listed for this dental care can only be extended for a period of sixty days from the date of the patient examination.

I grant my permission to you or your assignee contact me at any of the listed contact numbers or email addresses (including home, work, cell and email.)

I have read the above conditions of treatment and payment and agree to their content.
I hereby consent to services as diagnosed and agree to financial responsibility for said services.

____ **Date:** ____________ **Relationship to Patient:** ________________________
Signature of guarantor (financially responsible party)

COPPELL DENTISTRY FOR KIDS
OFFICE POLICIES AND GUIDELINES

Insurance Courtesy Notification

Coppell Dentistry for Kids 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 to inquire on the status of the claim. By initialing below you acknowledge that if your insurance company fails to remit payment after 60 days from date of service, the entire account balance is due in full by the responsible party.

Please note: WE ARE CONSIDERED **OUT OF NETWORK** FOR EVERY INSURANCE COMPANY EXCEPT DELTA PREMIER, CIGNA AND METLIFE.

Initial______________

Standard of Care

PLEASE READ: I understand that the standard of care for a *routine six month dental check-up* as prescribed by the American Dental Association and the American Academy of Pediatric Dentistry includes, but is not limited to, a professional dental prophylaxis (D1110;D1120 cleaning) followed by a professional topical fluoride application (D1208) and a comprehensive oral evaluation (D0150;D0120). Diagnostic x-rays (D0220;D0230;D0272;D0274) are typically taken once per year unless otherwise ordered by the Dentist. Individual insurance plan variables may affect coverage 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 and to explicitly inform the office staff should if any changes in the above mentioned standard are to be modified. We treat each child based upon need, not the dictation of your individual insurance policy.

Initial______________

Play Structure Rules

1. ALL CHILDREN must be supervised by a parent or other legal guardian while playing on or near equipment.
2. Children under the age of 3 must be accompanied by an adult while playing in the equipment.
3. No shoes allowed while playing on equipment.
4. No climbing on the outside of equipment.
5. Nothing is allowed to be taken into the play equipment.
6. No running or jumping near equipment.
7. No entering play equipment from the slide area.
8. Absolutely no sedated children allowed on play equipment.
9. No children allowed on play equipment after dental treatment.

I agree to the above rules and policy, I also understand that I take full responsibility for my child's supervision and safety while he/she is playing on or near the play structure equipment.

Initial______________

**Accompanied Minor Policy **

****PLEASE NOTE THAT OUR OFFICE REQUIRES A PARENT/LEGAL GUARDIAN TO REMAIN IN THE OFFICE FOR THE DURATION OF THE APPOINTMENT****

____ ________________________

Signature of responsible party **Date**

Financial Guidelines

Payment is due at the time of service.
We accept cash, checks and, for your convenience, MasterCard, Visa, Discover and American Express.
Our office does accept CARECREDIT for financial arrangements,
however we do not finance treatment internally.

We will file your insurance for you with the understanding that:

- Your insurance policy is a contract between you, your employer, and the insurance company. We are NOT a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurance company regarding deductibles, non-covered/covered charges, co-insurance, coordination of benefits, or "reasonable and customary" charges other than to provide factual information as necessary. Please understand that our fees are based upon the specific procedure, the time involved, the materials used, and the expertise and knowledge used to place those materials- therefore what an insurance company deems *usual and customary* specific to your insurance plan premiums, has no relevance in the determination of fee schedules.
- **We do not file secondary insurance**. We will provide you with a detailed statement so you may process your secondary insurance.
- **All charges are your responsibility whether your insurance company pays or not**. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.
- Fees for these services, along with unpaid deductibles and co-payments are due at time of treatment.
- If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help speed things up.
- If the insurance company does not pay your balance in full within 60 days, we require you to pay the balance due and resolve any further issues with your contracted insurance carrier.
- All accounts with a balance for 60 days or more will be subject to a monthly interest charge of 1.5% and may be forwarded to our collections attorney.
- Returned checks will be subject to a $35 service charge.

***Please note that, unless canceled at least 48 hours in advance, **you may be charged for missed appointments** at the rate of a normal office visit. ***

Again, thank you for choosing Coppell Dentistry for Kids. We appreciate your trust and the opportunity to serve you. Our goal is make dentistry fun for children so that they may establish the lifelong dental habits that are so important in maintaining good dental health.

Patients Name:________________________ Parent Signature:______________________Date:________

The following information is provided so as to allow you to make informed personal decisions concerning your child's dental treatment after considering the risks, benefits and alternatives. Please read this form carefully and ask about anything you do not understand.

It is my intent that all professional care delivered in this office shall be of the best possible quality I can provide for your child. It is very important that you appreciate that all treatment decisions in this office are based on the philosophy that we treat our patients the same way we would want our own children treated. Providing a high quality of care can sometimes be made very difficult, or even impossible, because of the lack of cooperation of some child patients. Behaviors that can interfere with the proper provision of quality dental care include: hyperactivity, resistive movement, refusal to open the mouth or keep it open long enough to perform the necessary dental treatment, and even aggressive or physical resistance to treatment such as kicking, screaming and grabbing the dentist's hands or sharp instruments.

My goal is to help children master the dental experience. Some children may cry as part of this learning process. Childhood emotions are intense and crying is a natural release of anxiety and/or an avoidance scheme. All efforts will be made to obtain the cooperation of our patients by use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding.

There are several recognized management techniques that are used by pediatric dentists to gain cooperation of children, to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. We combine the following recognized techniques individually for each child:

- **Tell-Show-Do:** The child is told what is to be done using simple words and then shown what is to be done using a model or finger. Then the procedure is done exactly as told. Praise is given to reinforce positive behavior. Children have less anxiety when they know what to expect.
- **Positive Reinforcement:** This technique rewards the child who displays any desirable behavior. Rewards include praise, compliments, a pat on the back, a gentle hug, a prize, etc…
- **Voice Control:** The attention of a child exhibiting disruptive behavior is gained by changing the volume tone of the dentist's voice. Content of the conversation is less important than the abrupt or sudden nature of the voice change.
- **Mouth Prop:** A device placed in the child's mouth to prevent accidental closing and/or injury. This also allows the jaw muscles to relax for ease of swallowing.
- **Physical Restraint by Dentist/Assistants:** The restraining of the child from undesirable movement by holding down the child's hands or upper body, stabilizing the child's head and/or controlling leg movements with the intention of preventing possible injury.
- **Nitrous Oxide/Oxygen Analgesia:** Nitrous oxide and oxygen analgesia is also known as "laughing gas" or "happy air." It smells good and its effects are completely removed five minutes after withdrawal. Many children find it helpful in managing dental anxiety. It provides a sensation of well being.
- **Conscious Sedation:** Sometimes a sedative drug is used to relax a child who does not respond to other behavior management techniques. Often this is an extremely young child who has extensive decay and who is unable to cooperate in the usual manner. This drug is administered orally and may be used in conjunction with nitrous oxide and oxygen analgesia. Sedations are not performed without parents being further informed and obtaining their specific consent for this procedure.
- **Hospital Dentistry or IV Disassociative Sedation:** For some children with medical complications, extensive decay at a very young age or in instances when conscious sedation is ineffective, dental treatment can be accomplished in a hospital operating room under general anesthesia or by IV disassociative sedation in the dental office. Additional information is provided to parents regarding this form of treatment.

I hereby authorize and direct Dr. Sonia Louca, assisted by other dentists and/or other health care providers as she may deem necessary, to utilize the behavior management techniques listed above on this form to assist in the provision of the necessary dental treatment with the exception of: (if none, state so) ____.

I hearby acknowledge that I have read and understood this consent and that all questions about the behavior management techniques described have been answered in a satisfactory manner.

Child's name: ____

Parent/Legal Guardian's Signature: ____________________________________ Date: _______________

Patient Acknowledgement and Consent Form

Effective April 14, 2003, the new federal law known as the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires that this office comply with certain rules regarding the maintenance of the privacy of your information that we have collected and will collect in the future.

To comply with one of the HIPAA requirements, Sonia Louca DDS PLLC is providing you with a copy of our Notice of Privacy Practices. This Notice of Privacy Practices contains the information that HIPAA requires us to disclose regarding our privacy practices. Existing Texas law requires (in addition to our attempt to obtain your written acknowledgement, discussed above) us to first obtain your written consent prior to disclosing any of your information except for our disclosures in connection with: a defense to a claim challenging our professional competence; a review of the entity's functions; a claim for payment of fees; a third party payer's examination of our records; a court order as part of a criminal investigation; an identification of a dead body; a licensure investigation; or a child abuse / neglect investigation.

In some instances, it may be necessary for us to make disclosures of your information in connection with your treatment. For example, we may make a referral to or consult with another covered entity for testing or otherwise make disclosures of your information in connection with providing or coordinating your treatment.

Patient Acknowledgment

Please sign this form below under the heading "acknowledgment" to acknowledge that you have today received a copy of our Notice of Privacy Practices.

I acknowledge that I have today received a copy of the Notice of Privacy Practices.

____
Patient Name (Please Print)

____
Patient or Parent/Guardian Signature

____
Date

Patient Consent & Authorization

Please sign this form below under the heading "Consent" to consent to our disclosures of your information that we deem necessary in order to provide you with proper treatment.

I consent to your disclosures of my information, which you deem are necessary in connection with my treatment.

Communication with laboratories or other specialists for any medical treatment, consultations, and educational purposes or for any other purpose deemed appropriate by Sonia Louca DDS PLLC.

____
Patient Name (Please Print)

____
Patient or Parent/Guardian Signature

____
Date

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For Office Use Only

Patient Refused to Sign

The following circumstances prohibited the patient from signing the Acknowledgement.

____
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____

____
Office Personnel Signature

____
Office Personnel Name (Please Print)