Children's Dental Clinic

132 S Horace ~ Tyler, Tx 75702

I HEREBY GIVE MY PERMISSION FOR ST. PAUL CHILDREN'S DENTAL, TO ADMINISTER TREATMENT, AND TO PERFORM SUCH PROCEDURES AS MAY BE NECESSARY IN THE DIAGNOSIS AND TREATMENT OF SAID MINOR CHILD OR MYSELF AND TO TAKE PHOTOS FOR CLINICAL USE ONLY. I AUTHORIZE ST. PAUL DENTAL TO RELEASE INFORMATION NECESSARY FOR INSURANCE CLAIMS.

I UNDERSTAND THAT THESE TREATMENTS WILL NOT BE RENDERED WITHOUT MY CONSENT.

☒ ______________________________

SIGNATURE OF PARENT/ GUARDIAN
DATE: ________________

I AGREE TO PAY FOR SERVICES RENDERED IN THE FOLLOWING WAY AT THE TIME OF TREATMENT…

- MEDICAID
- CHIP
- PRIVATE INSURANCE
- CASH
- CHECK
- CREDIT CARD

☒ ______________________________

SIGNATURE OF PARENT/ GUARDIAN

CHILD'S NAME: ____ AGE: ________

D.O.B.______________ Name Child Prefers to be called:______________________________

Weight:________________ Sex:______________ Race: ________________

➢ **CHILD'S MEDICAL HISTORY:** Please circle Yes or No

	Question		
1.	Does child have a health problem?	Y	N
2.	Is child under the care of a physician now?	Y	N
3.	Is there any history of excessive bleeding in child or family?	Y	N
4.	Has child had any emotional, mental or nervous problems?	Y	N
5.	Does child have a medical condition that requires antibiotics before dental treatment?	Y	N

6. Regular medications being taken by child: ________________________________
7. Medicines or drugs to which child is allergic:______________________________
8. Any other allergies:____
9. Previous hospitalizations:____
10. Is the Patient Pregnant: _______________________Due Date:________________
11. Has the child or any parents or siblings tested positive for Tuberculosis:__________

If yes for TB: date tested:_______________Physician Treating:___________________

Has this child had any history or difficulty with the following? Circle **Y**es or **N**o

Heart	Y	N	Rheumatic Fever	Y	N	Down syndrome	Y	N
Lungs	Y	N	Speech Problems	Y	N	Bleeding Disorder	Y	N
HIV/AIDS	Y	N	Fainting	Y	N	Cerebral Palsy	Y	N
Kidney	Y	N	Diabetes	Y	N	Cleft Lip / Palate	Y	N
Hepatitis	Y	N	Mumps/Measles	Y	N	Seizures	Y	N
Hearing	Y	N	Autism	Y	N	Tuberculosis	Y	N
Anemia	Y	N	Epilepsy	Y	N	Chronic Sinusitis	Y	N
Asthma	Y	N	Scarlet Fever	Y	N	Tobacco Use	Y	N
Chicken Pox	Y	N	Cancer	Y	N	Special Needs	Y	N

Explain all YES answers:____

CHILD'S DENTAL HISTORY: Circle Yes or No

Has child ever had any problems with local anesthetic, Nitrous Oxide (laughing gas), sedation or general anesthesia? Y N Explain if Yes: _______________________

Has child had a bad dental experience? Y N

Does child have any mouth habits (thumbsucking, nail biting, mouth breathing)? Y N

Last Dental Examination: Date_____________________Dentist:___________________

Last Dental X-rays:____

Please identify any dental or medical problem of special concern or provide any other information which you think might be important in the care of your child.______________

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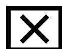
I have read and understand the posted HIPPA/Privacy Notice.

____

Signature

Responsible Party for payments?

 ____________________

Signature of Responsible Party

IF I AM NOT ACCOMPANYING MY CHILD,

____

____

____

(Name (s) OF adult) IS ALLOWED TO BRING THE CHILD OR MAKE DECISIONS IN REGARDS TO TREATMENT FOR MY CHILD. OR I WILL SEND A PERMISSION SLIP WITH MY SIGNATURE, PHONE NUMBER AND THE NAME OF THE ADULT ACCOMPANYING MY CHILD TO THE APPOINTMENT.

____

Parent / Guardian Signature

Date: ____________________

Relationship: ____________________

GENERAL INFORMATION: Patient's Name:______________________________

Contact Parent: ______________________________Age:________

Circle One
Mother Father Guardian Home Address:______________________________

City:____________________State:__________Zip Code:__________

Home Phone #:____________________Cell Number:____________________

Alternate Contact #______________E-mail Address:____________________

Driver's License #____________________D.O.B.____________________

Other Parent (*if applicable*): Name______________________________Age:________

Circle One
Mother Father Guardian Home Address:______________________________

City:____________________State:__________Zip Code:__________

Home Phone #:____________________Cell Number:____________________

Alternate Contact #______________E-mail Address:____________________

Driver's License #____________________D.O.B.____________________

What other children in your immediate family have we seen?____________________

____

Child's Pediatrician (physician):______________________________

How did you learn about St. Paul's Children's Dental Clinic?____________________

PRIVATE INSURANCE HOLDERS ONLY:

PLEASE COMPLETE THE FOLLOWING INFORMATION

Primary Insurance Company: ______________________________

Insurance Company Address:______________________________

Primary Insurance Holder's Name:______________________________

Primary Insurance Holder's Social Security #:____________________

Primary Insurance Holder's Relationship to Patient:____________________

Place of Employment for Primary Holder:____________________

Employer's Address:______________________________

Employer's Phone Number:______________________________

NO SHOW POLICY FORM & ACKNOWLEDGMENT OF PATIENT AND FACILITY RIGHTS AND RESPONSIBILITES

To best serve all our patients it is very important to fill every appointment with individuals that will show up for their given appointment.

If you miss three (3) appointments without calling to cancel or reschedule before your appointment time, we only see you for emergencies, then 30 days from that day your chart at our facility will be closed.

If Medicaid is your source of insurance and you miss three (3) appointments you may lose your Medicaid benefits.

I ____, understand that if I miss three (3) appointments, my children will no longer be a patient at St. Paul Children's Dental Clinic and I may lose Medicaid benefits.

By signing I also understand that Patient and Facility Rights and Responsibilities of our medical practice. These rights and responsibilities are posted at all times and a copy may be issued to you at any given time upon request.

____

Parent/Legal Guardian Signature   Date

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St. Paul Children's Dental Clinic Practice Manager   Date