



New Patient Packet

Patient Information

Patient Name: _____ Today's Date: _____
Last First MI

Preferred Name: _____ Gender: _____ Birth Date: _____

Primary Number: _____ (C/W/H) Secondary Number: _____ (C/W/H)

Address: _____
Street Apartment Number
City State Zip Code

Best Email Address to Confirm Appointments: _____

Does your child have any siblings we already treat? Yes No _____

Where does your child go to school or day care? _____ Phone Number _____

Referral Information

How did you find out about our office? Referred by another physician or dentist Referred by a friend Phonebook
 Another child in your family Other _____

Who can we thank for referring you to our office? Name: _____ Phone Number: _____

We value our patients feedback! Would you be open to receiving an invitation text to review our office? Your comments will help patients know what to expect when visiting our office. Yes No

Patient Dental History

What is the reason for your child's dental visit today? _____

Is this your child's first visit to the dentist? Yes No If no, when was the last visit?

Previous Dentist's Name: _____ Did they take x-rays at their last visit? Yes No

Have there been any injuries to the teeth, face, or mouth? If yes, please explain _____

Does your child have any major dental problems? Yes No Is your child taking fluoride supplements? Yes No

Is your child's water fluoridated? Yes No Does a parent assist with brushing/flossing your child's teeth Yes No

Does your child Floss his/her teeth daily? Yes No Does your child brush his/her teeth daily? Yes No

Do you think your child will react well to dental treatment? Yes No Explain _____

Has your child ever had a serious or difficult problem associated with previous dental work? _____

Does your child have any of the following habits? List all that apply. _____

Lip Sucking/Biting, Pacifier Habit, Nail Biting, Thumb/Finger Habits, Teeth Grinding, & Nursing/Bottle Habits.

Patient Health History

Name of child's Physician: _____ Phone Number: _____ Date of last physical exam: _____

Yes No Is your child currently under the care of a physician? If so, why? _____

Yes No Has your child ever been hospitalized? Emergency room? _____

Yes No Has your child had any surgeries or operations? _____

Yes No Is your child taking any medications? (Please give the name of medication, dose, and reason) _____

Yes No Does your child have any allergies to Medications, Foods, and/or Latex? _____



Asthma Related Questions

If your child has asthma, please read the following questions carefully and answer them with as much information as you can provide. Asthma can effect dental treatment for children in many ways and we need as many details as possible.

Does your child have asthma? **YES/NO** When was asthma diagnosed? _____

When was the last asthma attack? _____ Do you consider asthma controlled? **YES/NO**

When was the last medical evaluation for asthma? _____ Does your child carry an inhaler? **YES/NO**

Has your child ever been hospitalized due to asthma? **YES/NO** What causes the asthma attacks? _____

When was the last time the inhaler replaced? _____

Does your child take any medications for asthma? **YES/NO** _____

Has your child had an attack occur in a dental office? **YES/NO** How often do you replace the inhaler? _____

Has your child ever been diagnosed with the following: (Please check all that apply and explain any issues on the line provided below.)

No known health concerns

ADHD/ADD/Hyperactivity

Acid Reflux/GERD

Allergies-

Latex

Seasonal- _____

Food- _____

Medication- _____

Other- _____

Anemia

Anxiety

Arthritis

Artificial Joints/Stent

Asthma

Autism/Aspergers

Birth Defects

Blood Disease

Blood Transfusions

Cancer-

Treating Physician: _____

Phone Number: _____

Celiac Disease

Cerebral Palsy

Cleft Lip/Palate

Cystic Fibrosis

Depression

Developmental Delay

Diabetes

Dizziness

Epilepsy/Seizures

Eczema

Fainting

Glaucoma

Growths

Hay Fever

Head Injuries

Hearing Disorder

Hearing Problems

Heart Disease

Heart Murmur- Innocent

Requires Pre-med

Childs Weight _____ **lbs.**

Treating Specialist: _____

Phone Number: _____

Hepatitis- Type _____

High Blood Pressure

High Fevers

HIV/AIDS

Hydrocephalitis

Immunodeficiency

Jaundice

Kidney Disease

Learning Disabled

Liver Disease

Mental Disorders

MRSA

Nervous Disorders

Pacemaker

Physically Challenged

Pregnancy- Due Date: _____

Radiation Treatments

Respiratory Problems

Rheumatic Fever

Rheumatism

Scarlet Fever

Sensory Disorder

Sinus Problems

Speech Disorder

Stomach Problems

Stroke

Thyroid Condition

Tuberculosis

Tumors

Ulcers

Venereal Disease

Other: _____



Family Information

Mother's Information (Circle One): Mother Step-Mother Guardian
(Circle One): Married Divorced Single Other: _____

Name _____
Title Last First MI

Birth Date: _____ Social Security Number: _____

Occupation: _____

Primary Number: _____ (H/W/C) Secondary Number: _____ (H/W/C)

Address: _____
Street Apartment Number
City State Zip Code

Father's Information (Circle One): Father Step-Father Guardian
(Circle One): Married Divorced Single Other: _____

Name _____
Title Last First MI

Birth Date: _____ Social Security Number: _____

Occupation: _____

Primary Number: _____ (H/W/C) Secondary Number: _____ (H/W/C)

Address: _____
Street Apartment Number
City State Zip Code

Person Responsible for Account

Name _____ Relationship to Child _____
Title Last First MI

(Fill out only if Information is different from above)

Birth Date: _____ Social Security Number: _____

Primary Number: _____ (H/W/C) Secondary Number: _____ (H/W/C)

Address: _____
Street Apartment Number
City State Zip Code

Dr. Susie S. Hayden
Dr. Renee T. Mikulec



Dr. Courtney L. Alexander

Primary Dental Insurance Information

Please remember we use this information to submit claims on your behalf. We are not responsible for knowing your insurance plans frequencies and limitations. Our doctors will recommend treatment that is necessary for your child based on their needs, not your insurances frequencies and limitations.

Dental Insurance Company Name: _____

Name of Insurance Policy Holder: _____
Title Last First MI

Relationship to patient: _____ Insurance Phone Number: _____

Insurance Address: _____

Employer Name or Insurance Group Name: _____

Insurance Group Number: _____ Policy Holder's ID Number: _____

I am aware my insurance plan is _____ (Please write In Network or Out of Network)

Please be aware if your insurance is considered out of network you are responsible for any differences between our fees and your insurance fees. Please speak with the front desk if you have any questions before your appointment is started.

Secondary Dental Insurance Information

Please remember that we do not accept secondary insurance as a form of payment. We are happy to print out a claim for you to submit yourself, or we can submit the claim on your behalf for a \$15 fee per claim. For all secondary insurance claims we assign the benefits to you so that you receive all the reimbursement from the secondary insurance company.

Dental Insurance Company Name: _____

Name of Insurance Policy Holder: _____
Title Last First MI

Relationship to patient: _____ Insurance Phone Number: _____

Insurance Address: _____

Employer Name or Insurance Group Name: _____

Insurance Group Number: _____ Policy Holder's ID Number: _____

I am aware my insurance plan is _____ (Please write In Network or Out of Network)

Please be aware if your insurance is considered out of network you are responsible for any differences between our fees and your insurance fees. Please speak with the front desk if you have any questions before your appointment is started.



Authorization for Appointments

Please be aware that for any appointment in our office we must have authorization for anyone other than a parent or legal guardian to bring the child.

For future appointments I hereby authorize the following individuals to bring my child for dental treatment in my absence. They are authorized to sign any necessary documents. This person is authorized to be updated on all dental and medical information regarding my child from this appointment date, and any date in the past. I also understand that I am giving this person the responsibility to relay any information from the appointment to myself, and/or spouse.

The appointee may also authorize medical treatment and/or transportation to a hospital/emergency facility if deemed medically necessary.

Name:

Relationship:

1. _____
2. _____

****Please Initial the Following Statements****

_____ To the best of my knowledge, all of the preceding answers and information provided are true and correct. If the patient ever has any change in their health, I will inform the doctors at the next appointment without fail.

_____ As the parent or legal guardian of my child, I hereby authorize any doctor associated with Stone Oak Pediatric Dentistry and their designated representative to treat my child according to reasonable dental practices and standards.

_____ I hereby authorize Stone Oak Pediatric Dentistry to file claims and release any necessary information to my insurance company. I also hereby authorize assignment of benefits from my insurance company to Stone Oak Pediatric Dentistry. I understand and take full responsibility for any service that is not covered or not paid for by my insurance and/or any service rendered by Stone Oak Pediatric Dentistry.

Date: _____

Signature of Parent or Guardian

Printed Name of Parent or Guardian

NOTICE OF HIPAA COMPLIANCE

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or verbally, are kept strictly confidential. I have certain rights to privacy regarding myself, my child, children or legal guardian, and the protected health information. I understand that this information can and only will be used to:

Conduct, plan and direct my child, children or legal guardian, treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.

Obtain payment from third-party payers.

Conduct normal healthcare operations such as quality assessments and physician certifications.

I also understand that this gives consent to Stone Oak Pediatric Dentistry and its representatives to send phone, text or email communications regarding my child, children or legal guardianship.

Signature _____ Date: _____

Print Your Name: _____

Response Date: _____

SOPD, PLLC

www.sopdtx.com

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appointments@sopdtx.com

(210)491-4141

Welcome to Stone Oak Pediatric Dentistry. The following information is provided to you to ensure our families understand our office policies and your financial responsibilities when receiving treatment or services. We only want to do what is best for your children regardless of what your insurance policy may or may not pay. Should you have any questions our front office staff will be happy to help you.

1. FOR OUR RECORDS AND BILLING PURPOSES, PLEASE CONTACT OUR OFFICE SHOULD YOU HAVE ANY CHANGES TO YOUR ADDRESS, PHONE NUMBERS OR INSURANCE BEFORE YOU COME IN FOR YOUR APPOINTMENT.

2. Our office cancellation fee is \$55. These fees will be applied to your account each time you cancel or fail to come for an appointment without giving 24 hour notice.

3. As a courtesy to our patients and families, we will try to verify your child' s eligibility under our insurance company. However, we are not responsible for verifying your child' s benefits which includes frequency and limitations. Please contact your Human Resource department or insurance company for benefit information.

4. For any payments due on the day your child receives dental services, the person bringing your child will be responsible for payment of those services regardless of their relationship or legal responsibility.

5. Our staff processes your claim on your behalf. If we do not receive payment within 60 days from your date of treatment, you will be expected to pay the full amount due.

6. As an additional courtesy, we will file most primary insurance claims for you. However, secondary insurance claims may be filed on a case by case basis for a processing fee of \$15 per submission.

7. We follow the guidelines of the American Academy of Pediatric Dentistry, which recommends a fluoride treatment with every cleaning and taking two sets of films yearly on a six month interval to monitor carious lesions (watch areas/possible cavities).YOUR INSURANCE MAY NOT COVER THESE SERVICES EACH VISIT. PLEASE CONTACT YOUR INSURANCE TO FIND OUT HOW OFTEN THESE SERVICES ARE COVERED.

8. We will try to provide you with the best possible estimate for treatment. However we cannot foresee insurance downgrades for certain procedures, deductibles and how often your insurance covers certain services.

9. If your account has a balance, and it is not paid within 90 days, our office is happy to make payment arrangements with you. Please know if payment or arrangements have not been made within 90 days, your account will be forwarded to a collections agency and your account will be assessed a 30% administrative fee.

10. We respectfully ask for your cooperation in not directing financial questions to our doctors, assistants, or hygienists. Our Treatment Coordinators will be glad to help you with questions on costs or financial issues.

Relationship to Patient:

Mother

Father

Step-parent

Grandparent

Aunt

Uncle

Sibling

Guardian

Other- Please Explain _____

Print Your Name: _____

Signature _____ Date _____

Response Date: _____

Tongue Restriction Questionnaire (TRQ)

Name: _____ Gender: _____ Age: _____ Date: _____

Please check any issues that apply to help us determine if a tongue restriction may be present.

Baby Issues (Past or Present)

- Painful nursing or shallow latch
- Difficulty bottle-feeding
- Slow or poor weight gain
- Reflux or spitting up often
- Excessive gassiness or fussiness as a baby
- Prolonged feeding time at the breast or on the bottle
- Milk dribbling out of the mouth when eating
- Clicking or smacking noise when eating

Child to Adult Issues

- Frustration with communication
- Trouble with speech sounds, hard to understand, or mumbling
- Speech delay
- Slow eater or trouble finishing a meal
- Picky eater, especially with textures (e.g. meat, mashed potatoes)
- Choking or gagging on liquids or foods
- Spitting out food or packing food in cheeks
- Crooked, crowded teeth, or high arched palate
- Thumb or finger sucking or prolonged pacifier use
- Restless sleep (kicking or moving while asleep)
- Grinds teeth at night
- Sleeps with mouth open
- Snores (quiet or loud)
- Jaw joint (TMJ) issues (popping, clicking, or pain)
- Frequent headaches or neck pain
- Mouth breathing during the day
- Enlarged tonsils and/or adenoids
- Recurrent ear infections
- Frequent sinus issues/upper respiratory infections
- Hyperactivity or inattention

To be Completed by Healthcare Provider:

Tongue Elevation Exam: Grade 1 (>80%) / Grade 2 (50-80%) / Grade 3 (<50%) / Grade 4 (<25%)

Referral Recommended: YES / NO / MAYBE