New Patient Packet

Patient Information

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

Preferred Name:_____ Gender:_____ Birth Date: _____

Primary Number:_____ Secondary Number:_____

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 patient's 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 ◻NoDoes 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 affect 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 lines provided below)
If not please select "No known health concerns"

☐ **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**
☐ **Innocent Heart Murmur**
☐ **Heart Murmur** ☐ **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

Primary Parent Information: ☐ Mother ☐ Father ☐ Step Parent ☐ Legal Guardian _____

(Select 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

Secondary Parent Information: ☐ Mother ☐ Father ☐ Step Parent ☐ Legal Guardian _____

(Select 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 ☐ Mother ☐ Father ☐ Step Parent ☐ Legal Guardian _____

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

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 (Select One) ☐ In Network ☐ 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 (Select One) ☐ In Network ☐ 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 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.**
- **Email communications regarding my child, children or legal guardianship.**

Signature: _____Date: _____

Printed Name: _____ Relationship to Patient: _____

Our Office Policies

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, emails, or dental insurance **BEFORE** you come in for your appointment. We cannot guarantee same day verification of dental benefits if you do not provide the information ahead of time.

2. Our office **Cancellation Fee** is $55.00 for any appointments. These fees will be applied to your account each time you cancel or fail to come for an appointment without giving 24-hour notice, if you have a card on file it will be automatically charged the fee same day.

3. As a courtesy to our patients and families, we will try to verify your child' s eligibility under your insurance company. However, we are not responsible for verifying your child's benefits before each appointment which includes frequency and limitations. Please contact your Human Resource department or insurance company for benefit information. If you have questions about what is needed versus what is covered for your child's appointment please speak to front office staff **before** your appointment.

4. All payments are due at the time of service. 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. If you need to split payments between parents or legally responsible parties you are responsible for making those arrangements ahead of time and providing the information at the appointment on the day of service.

5. Our staff processes dental claims on your behalf at no charge to you. If we do not receive payment within 60 days from your date of treatment, any balances the insurance does not cover becomes your responsibility.

6. As an additional courtesy, we will file your primary dental insurance claims for you. However, secondary insurance claims may be filed on a case-by-case basis for a processing fee of $15 per claim per visit.

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 at the front desk.

11. Our office no longer accepts checks. We will accept cash, credit, or debit cards only. Flexible spending accounts or Health savings accounts through your insurance are also accepted.

Signature: _____Date: _____

Printed Name: _____ Relationship to Patient: _____

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%) *I* Grade 3 (<50%) *I* Grade 4 (<25%)

Referral Recommended: YES / NO / MAYBE