TRINITY
PEDIATRIC DENTISTRY

Tel: 682-207-6390
Fax: 682-207-6391
E-Mail: info@trinitypediatricdentistry.com
www.trinitypediatricdentistry.com 4000
Bryant Irvin Rd #208, Fort Worth TX 76109

PATIENT MEDICAL HISTORY

Patient Information: We welcome your child into our practice, and we will try to make his/her dental experiences very pleasant. Please complete this form thoroughly because this information is of great value in helping us to better understand and care for your child.

Appointment Date_____

Patient Legal Name (must match birth certificate):

Last: _____ First: _____ MI: _____ Nickname: _____

☐ Male ☐ Female Siblings & Ages _____

Birth Date: _____ Age: _____School: _____Grade: _____ Weight: _____

Address: _____ City: _____ State: _____ Zip: _____

Health Information: Has your child ever had any of the following? Check or write "yes". **If no health history – check here: NO HH ☐**

Autoimmune Disorder:	Cerebral Palsy:	Kidney Problems:	Pregnancy:
Seasonal Allergies:	Chicken Pox:	Liver Problems:	Respiratory Problems:
Anemia:	Diabetes I or II:	Lung Problems:	Rheumatic Fever:
Asthma:	Emotional Disorder:	Medications: please list below	Sinus Problems:
Autism:	Epilepsy:		Speech Problems:
Behavioral Problems:	Hearing Problems:		Surgeries:
Bleeding Disorder	Hepatitis:	Intellectual Disability:	Thyroid Disorder:
Blood Transfusion	Heart Condition:	Mononucleosis:	Tuberculosis:
Cancer:	Hospitalizations:	Mumps/Measles:	Vision Problems:

Please List any other pertinent health information including allergies to medications:

_____

Pediatrician: _____ Last Visit: _____ Phone: _____ Immunizations Up-to-Date? ☐☐ **Y** or **N**

Has your child been seen by another dentist? ☐☐ **Y** or **N** Name: _____ Date of Last Visit: _____

Dental procedures completed at last visit: _____ Has your child ever had a bad dental experience? ☐☐ **Y** or **N**

Does your child have a past or *current* history of thumb/finger sucking? ☐☐ **Y** or **N** Pacifier? ☐☐ **Y** or **N**

Was your child breast fed? ☐☐ **Y** or **N** Bottle Fed? ☐☐ **Y** or **N** Age Discontinued: _____

Consent for Services: As a condition of our treatment by this office, financial arrangements must be made in advance. The practice depends on the reimbursement from the patients for the cost incurred in their care and financial responsibility of on the part of each patient must be determined before treatment.

All emergency dental services, or any dental service performed without pervious financial arrangements, must be paid for in cash at the time services are performed.

Patients who carry dental insurance understand that this office as a courtesy will file insurance claims for the patient. I consent to the direct payment of my insurance benefits to Trinity Pediatric Dentistry and understand that my insurance benefits may pay less than the actual bill for services and that I am responsible for any services not paid or covered by my insurance benefits and any account balance.

I consent to the diagnostic procedures and dental treatment performed by my dentist and to the release of information concerning my (or my child's) healthcare, advice, and treatment to another dentist, or for evaluating and administering any claims for insurance benefits.

Responsible Party Signature: _____ Date: _____

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Mother's Information:

Last: _____ First: _____ MI: _____ Married: Y or N ☐ ☐

Email: _____ Birth Date: _____ Driver's License #: _____

Phone: Mobile: (_____) _____ Work: (_____) _____ Other: (_____) _____

Address (if different from child): _____ City: _____

State: _____ Zip: _____ Employer Name: _____Occupation: _____

Father's Information:

Last: _____ First: _____ MI: _____ Married: Y or N ☐ ☐

Email: _____ Birth Date: _____ Driver's License #: _____

Phone: Mobile: (_____) _____ Work: (_____) _____ Other: (_____) _____

Address (if different from child): _____ City: _____

State: _____ Zip: _____ Employer Name: _____Occupation: _____

Emergency Information: Relative not living in the same household.

Name: _____Relationship: _____ Phone: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Primary Insurance Information: *If we have already verified your insurance, you can check here: ☐ Insurance on file

Name of Insured: Last: _____ First: _____ MI: _____ Date of Birth: _____

Subscriber ID: _____ Group #: _____ Insured Phone #: (_____) _____

Address: _____ City: _____ State: _____ Zip: _____

Employer Name: _____ Occupation: _____ Employer Phone: (_____) _____

Insurance Plan Name and Address: _____

Insurance Phone #: (_____) _____ Patients Relationship to Insured (circle): Self Spouse Child Other_____

Do you have Secondary Insurance? Y or N ☐ ☐ If so please write information below:

_____

I hereby authorize payment of dental benefits otherwise payable to me, directly to Trinity Pediatric Dentistry.

Signature of Subscriber/Guardian: _____ Date: _____

Referral Information: Whom may we thank for referring you to our practice? (circle all that apply)

Another Patient (Friend) Another Patient (Relative) Dental Office School Work Drive By Google/Internet

Name of person or office referring you to our practice: _____

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TRINITY PEDIATRIC DENTISTRY FINIANCIAL POLICY

Trinity Pediatric Dentistry (TPD) is committed to providing you with the best possible care, and we are pleased to discuss our professional fees with you at any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, Financial Policy, or your responsibility.

- **All patients must complete the "Patient Information Form" before visiting with the dental professional.**
- **Full payment is due at time of service.**
- **We accept cash, checks, American Express, Visa, Mastercard, and Discover cards.**
- **TPD provides insurance company billing as a courtesy to our patients, the patient portion of particular dental service(s) is estimated and due at the time of service**

INSURANCE

Trinity Pediatric Dentistry provides insurance billing as a *courtesy* to our patients. The patient portion of a particular dental service(s) is estimated and due at the time of service. This amount may be subject to adjustment when the dental service(s) claim(s) are adjudicated by the insurance company. In addition, certain insurance companies have annual limitation for the amount of dental services that can be reimbursed within each plan year. If you or your family exceed these annual limitations in any plan year, you will be responsible for the full amount of dental services that exceed the particular plan's limitations. Some and perhaps all of the services can be defined by your insurance company as "not covered", "denied" or "over UCR". The patient is responsible for monitoring the amount of his/her remaining benefits for any annual benefit period.

The claims we submit to insurance companies indicate that you have assigned those benefits to TPD. However, if you are paid by the insurance company instead of TPD, you then become responsible for the total account balance and payment would be expected.

If you or your family has more than one dental insurance program, we will assist you in obtaining the maximum benefits available.

You as a patient are always responsible for any charges that are not covered by your insurance.

RETURNED CHECKS There is a fee ($40.00) for any checks returned by the bank.

MONTHLY STATEMENT

If you have a balance on your account, we will send you a monthly statement. It will show the previous balance, any new charges to the account, finance charge, if any, and any payments or credits applied to your account during the month. Professional fees are the responsibility of the parent or guardian authorizing treatment; we cannot send statements to other persons.

EMERGENCY/AFTER HOURS APPOINTMENT

If your child is seen for an emergency visit after our regular business hours, an "after hours" fee is charged in addition to any treatment on that visit. All emergency treatment must be paid in full at the time of service.

MISSED APPOINTMENTS

If appointments are cancelled within 24 hours a $25.00 fee will be charged to your account. Please help us service you better by keeping scheduled appointments.

Thank you for understanding and accepting our Financial Policy. Please let us know if you have any questions or concerns.

Patient's Name _____

Responsible party signature: _____ Date: _____

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CONSENT FOR ELECTRONIC COMMUNICATION & SOCIAL MEDIA

Deny Consent

I, (print name) _____, (circle one) **consent/deny consent** for Children's Dental to send me text/emails for appointment reminders, statements, office reviews, etc. I understand my information, images and/or videos will not be used for any other commercial purposes.

Deny Consent

I, (print name) _____, (circle one) **consent/deny consent** for Trinity Pediatric Dentistry to use photographs or videos of myself and/or my family members on their social media tools (Instagram, Facebook, etc.).

Signature: _____ Date: _____

PATIENT/RELATIVE HIPAA CONSENT

I understand that I have certain rights to privacy regarding my protected health information (PHI). These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand that by signing this consent I authorize you to use and disclose my PHI information to carry out: Treatment (including direct of indirect treatment by other healthcare providers involved in my treatment). Obtaining payment from third party payers (e.g. my insurance company). The day-to-day healthcare operations of your practice I have also been informed of, and given the right to review and secure a copy of you Notice of Privacy Practices, which contains a more complete description of e uses and disclosures of my PHI, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice. I understand that I have the right to request restrictions on how my PHI is used and disclosed to carry out treatment, payment, and health care operations, but that you are not required to agree to these requested restrictions. However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

I, _____, understand that by signing this Consent form, I am giving my consent to Trinity Pediatric Dentistry to disclose and discuss my protected health information to carry out treatment, payment activities and health care operations with the following family member(s):

Name: _____ Relationship: _____

Name: _____ Relationship: _____

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Initial Exam, X-Rays & Cleaning Informed Consent

Patient Name: _____ DOB: _____

Permission to Treat:

Because your child is a minor it is necessary to have signed permission from a parent or guardian. The signature affixed below authorizes examination and treatment as necessary and the use of procedures the doctor may deem necessary during the performance of dental services. Furthermore the undersigned accepts responsibility of any financial obligations incurred for treatment of this patient. (_____) initials

1. **Examinations and X-Rays:** I understand that the initial visit may include radiographs in order to complete the examination, diagnosis and treatment plan. I understand that Trinity Pediatric Dentistry will perform an examination, resulting in a patient diagnosis and treatment plan. It is Trinity Pediatric Dentistry's standard of care to perform two examinations a year and one to two sets of radiographs per year, depending on the patients dental risk. (_____) initials

2. **Dental Prophylaxis:** I understand that this type of cleaning is preventative in nature and intended for patients with healthy gums, and is limited to the removal of plaque, light tartar and stain from the tooth surfaces in the absence of periodontal (gum) disease. This type of cleaning prevents gingivitis and gum disease. (_____) initials

3. **Fluoride:** Fluoride is a safe and effective adjunct in reducing the risk of caries and reversing enamel demineralization.

   Please initial the fluoride option of your choice:

   I **consent** to the use of **Fluoride** (_____) initials **OR** I **deny** the use of **Fluoride** (_____) initials

Signature of Responsible Party: _____ Date: _____

Printed Name of Responsible Party: _____Relationship to Patient: _____