AUSTIN DENTISTRY

Patient Registration

To help us meet all of your child's dental needs please fill out this form ***completely and accurately.***

PATIENT INFORMATION

Name:_____ Birthdate:_____ Age:_____ Male/Female

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

Home Telephone #:_____ Alt. #_____

Do we see siblings? Yes/No If so, their names?_____

Whom may we thank for referring you to our office? _____

PARENT OR GUARDIAN e-mail:_____

Father's Name:_____ Birthdate:_____

Employer:_____ SS#_____

Home Telephone #:_____ Cell:_____ Work:_____

Mother's Name:_____ Birthdate:_____

Employer:_____ SS#_____

Home Telephone #:_____ Cell:_____ Work:_____

INSURANCE INFORMATION

As a **courtesy** we accept assignment of benefits from most insurance companies. In order to do so, you must provide us with the following information:

Policy Owner:_____ Relationship to patient:_____

Insured's SS#_____ Birthdate:_____ Employer:_____

Insurance Company:_____ Phone #:_____

Group name:_____ Group #:_____Address:_____

I authorize and request my insurance company to pay directly to the dentist or dental group any insurance benefits otherwise payable to me. **SIGNATURE**:_____

DENTAL HISTORY

Why is your child here today?_____

Is this your child's first dental visit? Yes/No. If no, when was the last dental visit?_____

How do you expect your child to behave today? Circle all that apply. Friendly / Happy / Anxious / Timid / Afraid / Resistant

Does your child receive fluoride in any form? Yes/No. If so, in what form?_____

Has your child inherited any dental characteristics?_____

Have there been any injuries to your child's teeth?_____

Please circle if your child has had any of the following problems or oral habits? Cavities / Toothache / Bad Breath / Crooked teeth / Sensitive to sweets / Bleeding gums / Sensitive to hot or cold / Frequent headaches / Discolored teeth / Loose teeth / Teeth bumped / Thumb sucking / Pacifier use / Lip biting / Teeth grinding / Other:_____

How often does your child Brush?_____ Floss?_____ At what age did your child stop using a bottle? _____

Sippy cup?_____

MEDICAL HISTORY

Child's physician:_____Phone #_____

Is your child in good general health? Yes/No. If no please describe:_____
Where there any problems at birth? Yes/No. If yes please describe:_____
Are your child's immunization and booster shots all up to date? Yes/No. Any drug or food allergies? Yes/No. If so please list and describe the type of reaction._____
Has your child had any surgical operations? Yes/No. If so, please describe:_____
Has your child ever been hospitalized? Yes/No. If yes, please explain:_____

Please circle yes or no for any of the following conditions you child has had or now has.

Allergies	Y / N	Eating Disorder	Y / N	Steroid therapy	Y / N
Asthma	Y / N	Abnormal bleeding	Y / N	Chemotherapy	Y / N
Heart trouble	Y / N	Blood transfusion	Y / N	Nervous/mental disorder	Y / N
Heart Murmur	Y / N	Birth defects	Y / N	Convulsions or seizures	Y / N
Rheumatic fever	Y / N	Kidney disease	Y / N	Frequent diarrhea	Y / N
Blood disease	Y / N	Cleft lip or palate	Y / N	Mumps or measles	Y / N
Anemia	Y / N	Scarlet fever	Y / N	Chicken pox	Y / N
AIDS virus	Y / N	High fever	Y / N	Cancer/tumor/cysts	Y / N
Diabetes	Y / N	High/low Blood pressure	Y / N	Sinus problems/drainage	Y / N
Ear/eye/nose/throat problem	Y / N	Liver disease	Y / N	Tuberculosis or TB exposure	Y / N
Stomach ulcer	Y / N	Jaundice/hepatitis	Y / N	Problems with anesthesia	Y / N
Thyroid disease	Y / N	Any other condition?_____			

CURRENT MEDICATIONS

Name/strength	How often?	Reason taken?

SOCIAL HISTORY

Circle if your child has any problems with the following? Speech / hearing / vision / sleep Do you consider your child to be? Advanced learner / progressing normally / slow learner Your child's first language?_____
Second language?_____ Is your child adopted? Yes / No. If so at what age?_____
How does your child tolerate medical or dental treatment?_____
Your child's favorite things? (Pet, toy, color, friend, hobby etc.)_____

Authorization and release: I understand that a payment of a calculated % is due at the time of treatment, and that my dental insurance carrier may pay less than the actual bill for service. I agree to be responsible for payment of all services rendered on behalf of my dependant(s), including any balance not paid by my dental insurance company within 30 days of the date of service. I understand that any unpaid balances may be sent to a collection company and I will be responsible for all collection charges. I understand that I am responsible for handling any disputes regarding amount of payment with the insurance company. I authorize and request my insurance company to pay directly to the dentist or dental group any insurance benefits otherwise payable to me. To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform this dental office of any changes in my child's medical status. I authorize this office to release any information, including the diagnosis and records of any treatment or examination rendered to my child during the period of such dental care to third party payers' and or other health practitioners.

SIGNATURE OF PARENT OR GUARDIAN:_____ DATE:_____

AUSTIN
DENTISTRY

FINANCIAL POLICY

INSURANCE BENEFITS

I understand it is my responsibility to inform and update this office of any changes in dental insurance coverage and also update any changes in address or contact phone numbers. I understand that this office requires ***24 hours*** notice in order to verify my child's coverage. If adequate notice is not given, I am aware that it is my responsibility to reschedule my child's dental appointment or pay the full fee of the visit.

UNPAID INSURANCE BENEFITS

All dental services provided, whether the patient has dental insurance or not, are charged directly to the financially responsible party and that he or she is personally **responsible for payment of all dental services**. If the insurance company has not paid a claim after 60 days of being submitted, this office will require the patient to pay the account balance unless other arrangements have been made. **It is your responsibility to know your plan and its limitations including but not limited to your deductible, plan maximum and coverage details.**

TREATMENT ESTIMATES

Austin Dentistry routinely provides our patients with an estimate of cost for the proposed treatment. Since ***your insurance*** determines the benefit payable for services, this office can not be held responsible for 100% accuracy on what is only an estimate for treatment. This office provides ***only an estimate*** based on your insurance coverage. All insurance companies provide a disclaimer when insurance benefits are being quoted:

"Information is subject to change. Benefits described are not a guarantee of payment. Actual benefits payments are determined only when a claim is received, eligibility is not a guarantee of coverage."

COLLECTION ACCOUNTS

If an account is turned over to a collection agency and or attorney for collection, the account holder will be responsible for all attorney and collection fees. **Any account that is 90 days past due is subject to being sent to collections.** Unless other arrangements have been made.

I hereby verify with my signature below that I have read and understood the office policies stated above and also grant Austin Dentistry and/or affiliates permission to contact me in matters related to this form.

PATIENT NAME:_____

SIGNATURE OF PARENT OR GUARDIAN:_____

WITNESS:_____DATE:_____

AUSTIN
DENTISTRY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE

OF PRIVACY PRACTICES

****You may refuse to sign this acknowledgement****

I, _____ have received a copy of this office's Notice of Privacy Practices.

PRINT NAME:_____

SIGNATURE:_____

DATE:_____

****For Office Use Only****

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please Specify)

_____

_____

_____

AUSTIN DENTISTRY

13616 N. Hwy 183, Ste. B, Austin, TX 78750

Date:_____

In my absence, I hereby give authorization for the person(s) listed below to bring my child(ren) to Austin Dentistry and to consent for any and all recommended dental/medical services.

Legal guardian must bring child to first dental appointment.

Child(ren) names and date of birth:	Authorized person(s)/Relationship to child(ren)
_____	_____
_____	_____
_____	_____
_____	_____

Parent/ Legal Guardian Signature: _____

Printed name:_____

This authorization will remain in effect until changes are made by the parent/guardian as signed above.

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AUSTIN
DENTISTRY

BEHAVIOR MANAGEMENT TECHNIQUES

It is our intent that all professional care delivered in our dental clinic be the best possible quality we can provide for each child. Providing a high quality of care can sometimes be made very difficult, or even impossible, due to the lack of cooperation of some child patients. Among the behaviors that can interfere with the proper provision of quality dental care are: hyperactivity, resistive movements, refusing to open mouth or keep open for long enough to perform the necessary dental treatment. Also, aggressive or physical resistance such as kicking, screaming, grabbing the dentists hands or sharp instruments can prevent the proper treatment being performed.

All efforts will be used to obtain the cooperation of the adolescent patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness and understanding.

There are several behavior management techniques that are used by pediatric dentists to gain the cooperation of adolescent patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. The more frequently used pediatric dentistry behavior management techniques are as follows:

1. Tell-show-do: The dentist or assistant explains to the child what is to be done using simple terminology and repetition. Then the dentist or assistant shows the child what is to be done by demonstrating on a model or the child's or dentist's finger. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior
2. Positive reinforcement: This technique rewards the child who displays any behavior that is desirable. Rewards include compliments, praise, a pat on the back , a hug or a prize.
3. Voice control: The attention of a disruptive child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is less important than the abrupt or sudden nature of a command.
4. Mouth props: A rubber or plastic device is placed in the child's mouth to prevent closing when a child refuses or has difficulty maintaining an open mouth.
5. Sedations: Sometimes drugs are used to relax a child who does not respond to other behavior management techniques or is unable to comprehend or cooperate for dental procedures. These drugs may be administered orally, by injection or as a gas (nitrous oxide and oxygen). The child does not become unconscious. You child will not be sedated without you being further informed and obtaining your specific consent for such a procedure.
6. General anesthesia: The dentist performs the dental treatment with the child anesthetized in a hospital operating room. Your child will not be given general anesthesia without you being further informed and obtaining your specific consent for such a procedure. INITIALS:_____DATE:_____

AUSTIN
DENTISTRY

PEDIATRIC DENTISTRY CONSENT FOR DENTAL PROCEDURES

AND ACKNOWLEDGEMENT OF RECEIPT OF INFORMATION

It is the policy of this dental practice to inform parents of all procedures contemplated for your child. At each examination appointment, we will identify any dental treatment needed and describe this to you and your child. Each regular examination visit consists of oral hygiene instructions, cleaning of the teeth, topical application of fluoride, radiographs (x-rays) if needed, and examination of the teeth, hard and soft tissues of the mouth and the bite. Any other treatment needed such as fillings, caps, extractions, etc., will be preformed at a separate appointment after obtaining your permission.

State law requires that we obtain your written informed consent for any treatment given to your child as a legal minor.

1. I, hereby authorize and direct the doctor(s) of Austin Dentistry assisted by dental auxiliaries of his or her choice, to perform upon my child the following dental treatments or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.
2. In general terms the dental procedures or operation may include:

   A. Cleaning of the teeth and the application of topical fluoride.

   B. Application of plastic "sealants" to the grooves of the teeth.

   C. Treatment of the diseased or injured teeth with dental restoration (fillings or caps)

   D. Replacement of missing teeth with dental prosthesis.

   E. Treatment of malposed (crooked) teeth and or oral developmental or growth abnormalities.

   F. Use of local anesthesia, by injection, to numb the teeth worked on. Numbness usually lasts form 1 1/2 to 3 hours.

   Allergic reactions are rare and your child will be cautioned not to bite the numb lip and cheek. Please do not tell your child they are going to get a "shot", we have a special way of informing them of this that prevents fear.

   G. Use of nitrous oxide (laughing gas) may be used to help children relax and feel the injection less. This gas is placed over your child's nose after an explanation is given. This gas is very safe when used in the concentration that will be used, and the nose piece, as with all treatment, will not be forced upon your child.

   H. Use of behavior management techniques outlined on page 2.

I fully understand there is a possibility of surgical and/or medical complications developing during or after the procedure. These risks and side effects may include adverse reaction to a drug that may cause necessary hospitalization, further surgical procedures, disability, system impairment, permanent or temporary nerve damage, brain damage or death. I further authorize the doctors of Austin Dentistry to perform treatment as may be advisable to preserve the health and life of my child.

I further understand that parents may be asked to remain in the reception area if needed for behavior management or for the benefit of the success of the treatment.

I hereby state that I have read and understand this consent and the behavior management techniques on page 2 and that all questions about the procedures have been answered in a satisfactory manner. I also understand that I have a right to be provided with answers to questions which may arise during the course of my child's treatment..

I further understand that this consent will remain in effect until such time that I choose to terminate it.

DATE:_____TIME:_____am/pm

PATIENT:_____SIGNATURE OF PARENT OR GUARDIAN:_____

RELATIONSHIP TO PATIENT:_____WITNESS:_____