tylerpediatric DENTISTRY

Donald Ritchie, DDS . 903-531-9000 . www.donaldritchiedds.com

ABOUT YOUR CHILD:

Name:_____

Nickname: _____ ❑Male ❑Female

Birthdate:_____

SSN:_____

Home Address:_____

_____

(Apt #) (City) (State) (ZIP)

Home Phone: _____

School: _____

Grade: _____

Child's Hobbies, favorite games: _____

_____

ABOUT YOUR FAMILY:

Mother's Information

❑ Married ❑Single ❑Guardian ❑Step Mother ❑Foster Parent

Name:_____

Address (if different from patient):

_____

Birth Date:_____ SSN:_____

Employer:_____ Work Phone:_____

Home Phone:_____ Cell Phone:_____

Driver's License:_____ Exp:_____

Email Address: _____

Father's Information

❑ Married ❑Single ❑Guardian ❑Step Father ❑Foster Parent

Name:_____

Address (if different from patient):

_____

Birth Date:_____ SSN:_____

Employer:_____ Work Phone:_____

Home Phone:_____ Cell Phone:_____

Driver's License:_____ Exp:_____

Email Address: _____

Emergency Contact Phone Number:_____

DENTAL HISTORY:

Is this your child's 1st dental visit? _____ If no, what was the approximate date of the last visit?_____

Has your child been seen by another dentist? _____ Name: _____

Was there a previous unfavorable medical/dental experience? _____ If so, please explain: _____

_____

Does your child receive fluoride tablets, drops, vitamins, or a rinse? _____

Does your child brush his or her teeth daily? _____ Do you assist them? _____

At what age was bottle or breast feeding stopped? _____

Does your child have any of the following? ❑ Dental Pain ❑ Swelling ❑ Cavities ❑ Sores in Mouth ❑ Injured Teeth

❑ Thumb/Pacifier ❑ Sealants ❑ Extracted Teeth ❑ "Crooked Teeth" ❑ Fillings

What do you predict your child's behavior to be? ❑ Cooperative ❑ Fearful ❑ Defiant ❑ Don't Know

What are your concerns about your child's teeth? _____

_____

Does your child have any of the following habits?

❑ Thumb/finger sucking

❑ Pacifier

❑ Lip sucking/biting

❑ Nail biting

❑ Nursing/bottle habits

❑ Mouth breathing

❑ Nighttime grinding of teeth

REFERRAL INFORMATION:

Whom may we thank for referring you to our practice?

❑ Another Patient _____

❑ Dental Office _____

❑ Doctor's Office _____

❑ Google ❑ Drive By ❑ School ❑ Work

❑ Other _____

DENTAL INSURANCE:

Dental Insurance Co. _____

Insurance Co. Phone # _____

Group: (Plan, Local or Policy) _____

Insured's Name: _____

Insured's DOB: _____

Insured's SSN: _____

Relationship to Patient: _____

Employer: _____

Employer's Address: _____

Employer's Phone Number: _____

For our patients with dental insurance, we will be happy to file insurance claims for you as long as your insurance can be verified. We ask you to pay all non-covered fees as treatment progresses.

_____

Signature of Parent/Guardian Date

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MEDICAL HISTORY:

- ❑ Anemia
- ❑ Asthma/Lung Problems
- ❑ Birth Defects
- ❑ Bleeding Problems/Transfusions
- ❑ Blood Pressure Problems
- ❑ Cerebral Palsy
- ❑ Cleft Lip/Palate
- ❑ Delayed Development
- ❑ Heart Problems/Murmurs
- ❑ Diabetes
- ❑ Ear Infections/Tubes
- ❑ Fainting Spells
- ❑ Hearing or Vision Loss/Impairment
- ❑ Herpes
- ❑ Kidney Disease
- ❑ Liver Diease/Hepatitis
- ❑ Malignancy, Cancer
- ❑ Latex Allergy/Sensitivity
- ❑ Mental Emotional Problems
- ❑ Pregnant
- ❑ Premature/Low Birth Weight
- ❑ Psychiatric Problems
- ❑ Immunologic Disorders/HIV
- ❑ Rheumatic Fever
- ❑ Seizures/Epilepsy
- ❑ Sickle Cell Anemia/Trait
- ❑ Speech Problems
- ❑ Other _____

Pediatrician's name: _____ Last Visit: _____ Phone Number: _____
Is your child allergic or had any adverse reaction to a medication? _____
If yes, please explain:_____
List any medications your child is currently taking, the dosage, and what it is taken for: _____
_____
Has your child ever been hospitalized or treated in an emergency room? When? _____Why?_____
_____

CONFIRMATION & MISSED APPOINTMENT POLICY

We are dedicated to provide the best dental care possible for your child. We want to give your child the time and individual attention they deserve. In a sincere effort to acknowledge the importance of each parent's time, and to remain on time during our busy schedule, we must ask the parents to **ARRIVE ON TIME FOR THEIR CHILDREN'S APPOINTMENT**. This allows us to be able to see all the children that are scheduled in a timely and efficient way. When a parent is late or fails to make a scheduled appointment, this may jeopardize all the children's treatment. It also affects the other parent's schedules that have appointment times after your child that day.

- Please call our office if you are going to be late for your appointment.
- If a patient is more than 15 minutes late, we may need to reschedule the appointment. If we are able to see your child, we cannot guarantee that all treatment will be completed.

In an effort to serve all children that have dental needs, we must ask that you acknowledge our missed appointment policy. A time is specifically set aside for your child's dental appointment. Should you miss a restorative appointment, you will be assessed a "missed appoint" fee of $30.00. At that time, you will be rescheduled for the missed appointment, and will be required to prepay your child's next appointment.

- Parents may change or cancel their child's appointment with at least 24 hours notice.

Parent/Guardian Signature _____ Date_____

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OFFICE BILLING & INSURANCE POLICIES

Payments
Payments are due the day services are performed. Payment is accepted in the form of cash, check, debit cards, or credit cards (Visa mastercard, Discover or American Express).

Insurance
Your insurance plan is an agreement between your insurance company and you. We file claims to your insurance company as a courtesy to you. After 30 days, we ask that you call your insurance company if no payment has been received. After 60 days, any outstanding insurance balance will be your responsibility. Also, please understand, you are responsible for the balance of charges incurred regardless of your insurance payment.

Billing
You may incur a finance charge of 1.5% on your account if your balance is not paid in 60 days or less. Please inform us of any financial concerns so an agreement can be made up front of how the account will be paid. I also agree that should it become necessary to forward my account for collections, in addition to the amount owed, I will also be responsible for the fees associated with the costs of collections.

Authorization
I have read and understand the above written financial policy; I hereby authorize payment of insurance benefits directly to Healthy Smiles for Kids, otherwise payable to me. I understand that I am ultimately responsible for all costs of dental treatment not covered by insurance. The responsible party is the parent/guardian that brings the child to the dental office and seeks treatment, independent of what a divorce decree may state. Reimbursement must be made between divorced parties; we will not intervene.

Signature _____ Date_____

HEALTH INFORMATION PRIVACY POLICY ACT (HIPPA)

Child/Children's Names: _____
Parent/Guardian's Name: _____
Phone Number: _____ Work: _____ Cell: _____
Address: _____

In general, the HIPPA privacy rule gives individuals the right to request a restriction of their health information. The individual is also provided the right to request confidential communications or that a communication of PHI (Protected Health Information) be made by alternative means, such as, sending information to the individual's office instead of their home.

I wish to be contacted in the following manner (check all that apply):
Home Telephone
❑ Ok to leave message with details ❑ Ok to speak to spouse/sibling
Work Telephone
❑ Ok to leave message with details ❑ Leave message with call back
Written Communication
❑ Ok to mail to my home ❑ Ok to fax to designated number

I give Dr. Ritchie permission to use and disclose PHI necessary to carry out TPO (Treatment Payment or Operations). This is also indicated a "Good Faith Effort" was made on behalf of Dr. Ritchie. By signing this form, I understand that the privacy practices of this office have been disclosed to me. This information will stay on record for six years.
Signature _____ Date_____

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Appointment Authorization

I, _____, **AUTHORIZE** the listed persons below to 1.) Bring my child/children to their dental appointment and 2.) Consent to any treatment deemed necessary. We will also **require** a six-month medical update form to be completed at your child's appointment, thus making the person bringing my child to the appointment **responsible** for any medical changes, current medications and dental concerns.

If your child is coming to his/her appointment on their own, arrangements to have a parent complete the six-month medical update form will have to be made **prior** to the appointment. A person under the age of 18 years old cannot complete the medical update form.

Child/Children's Name(s): _____

Authorized Person:

1. _____ Relationship _____
2. _____ Relationship _____
3. _____ Relationship _____

Mother/Guardian: _____ Contact Number _____

Father/Guardian: _____ Contact Number _____

Signature: _____ Date: _____

COPY OF CURRENT PHOTO ID MUST ACCOMPANY THIS FORM.

Wellness Form

First Name | Last Name | Phone | Email

Do you have a cough?

Yes No

Do you have a fever now or have you in the past 14-21 days?

Yes No

Have you come in contact with any confirmed COVID-19 positive patients in the last 14 days?

Yes No

Are you experiencing shortness of breath or difficulty breathing?

Yes No

Are you experiencing other flu-like symptoms, such as gastrointestinal upset, headache, or fatigue?

Yes No

Have you experienced recent loss of taste or smell?

Yes No

Are you over the age of 60?

Yes No

Do you have heart disease, lung disease, kidney disease, diabetes or any auto-immune disorders?

Yes No

Have you traveled in the past 14 days to any regions affected by COVID-19? (as relevant to your location)

Yes No