Child's Name _____
Last Name First Name Middle Initial

□ Male
□ Female Age_____ Birthday___/____/____ Nickname_____ Hobbies_____

Home Address _____
Street Apt # City State Zip Code

Mailing Address _____
Street Apt # City State Zip Code

Home Phone #_____ Mom Cell#_____Dad Cell#_____

How did you hear about us?_____

Email Address:_____

PARENT' S INFORMATION

Circle One:
Father Stepfather Guardian
Name_____
Date of Birth:____/____/_____
Address (if different from patient)
_____
Home Phone_____

Work Phone_____

Employer_____
SSN#: _____

Do you have dental insurance coverage for a minor/child? YES NO

Circle One:
Mother Stepmother Guardian
Name _____
Date of Birth:_____/_____/_____
Address (if different from patient)
_____
Home Phone_ _____

Work Phone_____

Employer_____
SSN _____

Do you have dental insurance coverage for a minor/child? YES NO

PRIMARY INSURANCE

Subscriber Name:_____
Subscriber SSN#:_____
Subscriber Date of Birth:___/___/_____
Insurance Co._____
Group #_____
Policy/I.D. #_____

SECONDARY INSURANCE

Subscriber Name:_____
Subscriber SSN#:_____
Subscriber Date of Birth:_____/___/_____
Insurance Co. _____
Group #_____
Policy/I.D. #_____

Patient Name: _____ **Date of Birth:** _____ **Date** _____

DENTAL HISTORY

Date of last visit to a dentist ___/___/____Last Cleaning___/___/____ Last X-Rays ___/___/_____
Reason(s) for seeking dental care:

_____First Examination _____Routine Check-Up _____Second Opinion
_____Toothache or Swelling _____Accident _____Other:_____

Do you have any concerns or issues regarding your child's dental health that you would like to be addressed?

_____

Has your child had any negative dental experiences? _____If yes, please explain

_____

How do you expect your child to react to the visit today?
_____Excellent _____Good ____Fair _____Poor _____Not sure

Is fluoride taken in any form? YES NO
___In vitamins ____In Water _____Drops/Tablets _____Rinse/Gel

Does your child brush teeth daily? YES NO

Does child floss every day? YES NO

Any injuries to mouth, teeth, head? YES NO
If yes, at what age?_____Which teeth?_____
What caused the injury?_____Treatment received?_____

Any mouth habits? YES NO
__Thumb/Finger Sucking __Nail biting __Mouth Breathing ___Pacifier ___Sleeping with bottle
Other (please explain)_____

EMERGENCY CONTACT

In the event of an emergency, whom should we contact?
Name_____Relationship_____Phone#_____
Name_____Relationship_____Phone#_____

PHOTO CONSENT

I _____, give consent for Cibolo Pediatric Dentistry to capture a photographic imagery of my child _____, for their records. I understand that Cibolo Pediatric Dentistry staff will have access to their photo in the dental record.

Patient/Guardian Signature_____ **Date**_____

Patient Name: _____ **Date of Birth:** _____ **Date:** _____

CONSENT FOR TREATMENT

The information that I have given is correct and complete to the best of my knowledge. It will be held in the strictest confidence, and it is my responsibility to inform this office of any changes in my child's medical status. I am the legal guardian of the patient.

I authorize the Dentist and Staff to perform the necessary dental procedures: complete dental examination (check-up), prophylaxis (cleaning), fluoride treatment, radiographs (x-rays), sealants, study models, and other diagnostic/preventive aids deemed necessary by the Dentist and the staff to make a thorough diagnosis of my child's dental needs.

I authorize the Dentist and Staff to provide any information to other Doctors (physicians, dentists, etc.) for the purpose of consultation. I understand that prior to providing any treatment, I will be advised about such treatment, that I may ask questions concerning the treatment, and that I may revoke this BEFORE treatment is provided. As the parent/legal guardian of the patient, I do hereby grant the dentist and the staff permission to perform any needed treatment(s).

Patient/Guardian Signature_____ **Date**_____

APPOINTMENT AUTHORIZATIONS

For future appointments, if you are planning to send your child with someone other than a parent/legal guardian, please provide the following information (must be 18yrs or older): Name of authorized person(s) to accompany my child for future treatment visits:

1. **NAME:**_ _____**Relationship to Child:**_____
2. **NAME:**_ _____**Relationship to Child**:_____

FINANCIAL AGREEMENT

- **Your insurance is a contract between you, your employer, and the insurance company; our relationship is with you, NOT the insurance company. We file your insurance claim as a courtesy to you.**
- **ALL charges incurred are charged directly to YOU and you are personally responsible for payment. Deductibles and co-payments are due at the time of treatment. We ESTIMATE your co-payments according to your policy. We DO NOT in any way guarantee that your insurance will pay this amount.**
- **If the insurance company doesn't pay within a 60 days, it is required that you pay the balance due.**
- **Your insurance card must be presented at every visit. If there is no insurance card, then payment (cash, check, or credit card) is expected at the time of service.**
- **I hereby authorize payment directly to Cibolo Pediatric Dentistry, the insurance benefits otherwise payable to me, and authorize release of any information required to process insurance claims.**

Patient/Guardian Signature_____ **Date**_____

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I, _____ have reviewed a copy of Cibolo Pediatric Dentistry
(Parent or Legal Guardian's Name)
Notice of privacy Practices regarding my son/daughter _____.

Patient/Guardian Signature _____ **Date** _____
OFFICE USE ONLY: __Patient Refused to Sign __Emergency Situation __Language Barrier __Other

Patient Name:_____ Date of Birth:_____ Date:_____

Appointment Policy

We reserve time in our schedule especially for your child, and in consideration of others we request at least **48 hours notice prior to cancellation of appointments**. We do understand that there are circumstances that may prevent you from keeping your child's appointment, however, with providing us as much notice as possible we may be able to contact another family who would like that appointment time. Afternoon appointments fill quickly, and canceling with less than 48 hours notice does not allow us enough time to schedule another patient in need of treatment. After the second missed appointment, you will be asked to pre-pay for your child's appointment before we will reserve time on our schedule. Patients that are running late are asked to call the office as soon as possible to check with the staff if they will still be able to keep their appointment. Also, cancellations are not accepted if left on the answering service and the appointment will not be considered cancelled unless you call during regular business hours and speak with one of our scheduling coordinators.

Patients may have their appointments rescheduled if they are more than 10 minutes late for their appointment time in consideration for other patients.

Appointments cancelled with less than 48 hours notice on a school holiday, an after school time, or Saturday will not be rescheduled on another school holiday, Saturday or after school appointment time, as they are our most popular appointments.

We greatly appreciate your cooperation in helping us provide you with excellent care for your family. Please sign below that you have read, and acknowledge the above information provided to you. We will provide a copy for your records.

Patient/Guardian Signature_____ Date_____