



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** \_\_\_\_\_



## OFFICE SOCIAL MEDIA CONSENT

\_\_\_\_\_ I give Cibolo Pediatric Dentistry permission to display my child's name and picture/video on the office: Facebook, Instagram, Snapchat.

\_\_\_\_\_ I give Cibolo Pediatric Dentistry permission to display my child's picture/video ONLY on the office: Facebook, Instagram, Snapchat.

\_\_\_\_\_ I do NOT give permission for my child's picture/video to be displayed on the office: Facebook, Instagram, Snapchat.

Patient's Name: \_\_\_\_\_-

\_\_\_\_\_  
Parent / Legal Guardian

(Please Print)

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date