Bellmead KID'S DENTISTRY

Patient Information

Patient Name: _____ Date: _____
Last First MI (Preferred Name)

Birth Date: _____ Age: _____ Gender: _____ Weight:_____ Height: _____

Phone (Hm):_____ (Wk):_____ (Cell):_____ (Alt #):_____

Address: _____
Street Apartment #

_____
City State Zip Code

Health Information

Have you ever had any of the following? Please check those that apply:

Abnormal Bleeding
ADD/ADHD
Aids
Asthma
Blood Disease
Cancer
Diabetes
Excessive Bleeding
Heart Disease
Heart Murmur
Hepatitis
Autism/Asperger
Mental Disorders
Nervous Disorders
Rheumatic Fever
Seizures
Tuberculosis
Codeine Allergy
Penicillin Allergy

Other:_____

_____

Current Medication:

_____

Reason for this visit: _____ Date of Last Visit: _____

- Have you ever had any complications following dental treatment? Yes No
  If yes, please explain: _____
- Have you been admitted to a hospital or needed emergency care during the past two years? Yes No
  If yes, please explain: _____
- Are you now under the care of a physician? Yes No
  If yes, please explain: _____
- Name of Physician: _____ Phone: _____
- Do you have any health problems that need further clarification? Yes No
  If yes, please explain: _____

To the best of my knowledge, all of the preceding answers and information provided are true and correct. If I ever have any change in my health, I will inform the doctors at the next appointment without fail.

_____ Date: _____
Parent/Guardian Signature

Medical History Updated: ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ ____ __

Patient/Guardian Information

Father _____ Birth Date: _____

Social Security #: _____ Driver's License #: _____

Mother: _____ Birth Date: _____

Social Security #: _____ Driver's License #: _____

Phone (Hm):_____ (Wk):_____ (Father):_____ (Mother):_____

Email: _____

Address: _____
Street **Apartment #**

_____
City **State** **Zip Code**

Marital Status: Married Divorced Separated Other _____
Emergency Contact: Name: _____ Phone: _____

Referral Information

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

Employment Information

Employer Name: _____ Phone: _____

Address: _____
Street City State Zip Code

Insurance Information

Primary
Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

_____

Secondary
Name of Insured: _____ Is insured a patient? Yes No
Last First MI

Insured's Birth Date: _____ **ID #:** _____ **Group #:** _____

Insured's Employer Name: _____

Patient's relationship to insured: Self Spouse Child Other _____

Insurance Plan Name and Address: _____

_____

INSURANCE AUTHORIZATION, ASSIGNMENT, AND CONSENT FOR SERVICES

I hereby authorize Bellmead Kid's Dentistry to furnish information to insurance carriers concerning my dental treatment and I hereby assign to the dentist all payments for dental services rendered to my dependents. I understand that I am responsible for any amount not covered by insurance. I hereby authorize Dr. Susan Francis, and Associates to render dental treatment to my child, I have read the conditions of treatment and payment and agree to their content.

_____ Date: _____ Relation to Patient: _____
Signature of parent or guardian

_____ Date: _____ Relation to Patient: _____
Signature of guarantor of payment/responsible party

HIPPAA OMNIBUS RULE

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND CONSENT/ LIMITED AUTHORIZATION & RELEASE FORM

You may refuse to sign this acknowledgement & authorization. In refusing we may not be allowed to process your insurance claims.

Date: _____

The undersigned acknowledges receipt of a copy of the currently effective Notice of Privacy Practices for this healthcare facility. A copy of this signed, dated document shall be as effective as the original. **MY SIGNATURE WILL ALSO SERVE AS A PHI DOCUMENT RELEASE SHOULD I REQUEST TREATMENT OR RADIOGRAPHS BE SENT TO OTHER ATTENDING DOCTOR / FACILITIES IN THE FUTURE.**

_____ _____

Print name of Patient | Sign name of Patient/Guardian

_____ _____

Legal Representative/Guardian | Relationship of Legal Representative/Guardian

Your comments regarding Acknowledgments or Consents: _____

_____

How do you want to be addressed when summoned from the reception area:

First Name Only Proper Sir Name Other: _____

Please list any other parties who can have access to your health information:

(This included step parents, grandparents and any care takers who can have access to this patient's records)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize contact from this office to **CONFIRM MY APPOINTMENTS, TREATMENT, AND BILLING INFORMATION** via:

Cell Phone Confirmation	Text Message to my Cell Phone
Home Phone Confirmation	Email Confirmation
Work Phone Confirmation	**Any of the above**

I authorize **INFORMATION ABOUT MY HEALTH** be conveyed via:

Cell Phone Confirmation	Text Message to my Cell Phone
Home Phone Confirmation	Email Confirmation
Work Phone Confirmation	**Any of the above**

I approve being contacted about **SPEACIAL SERVIES, EVENTS, FUNDRAISING EFFORTS or NEW HEALTH INFO** on behalf of this Healthcare Facility via:

Phone Message	**Any of the Above**
Text Message	**None of the Above** (Opt out)
Email	

In signing thiis HIPAA Patient Acknowledgement Form, you acknowledge and authorize that this office may recommend products or services to promote your improved health. This office may or may not receive third party remuneration from these affiliated companies. We, under current HIPAA Omnibus Rule, provide you this information with your knowledge and consent.

Office Use Only:

As Privacy Officer, I attempted to obtain the patient's (or representatives) signature on this Acknowledgement but did not because:

It was emergency treatment	_____	
I could not communicate with the patient	_____	
The patient refused to sign	_____	
The patient was unable to sign because	_____	
Other (please describe)	_____	_____

Please Read

Please take time to read over our office policies.

1. Please **NEVER LEAVE CHILDREN** in the waiting area unattended.
2. **NO SIBLINGS** are allowed with the patient while treatment is being completed – Patient for exams and cleanings; siblings are ok.
3. **ONE PARENT/GUARDIAN** is allowed with the patient in the room while treatment is being done.
4. **24 HOUR CANCELLATION NOTICE** is required for all appointments, so that we may have time to move other patients forward

   WE RESERVE THE RIGHT TO CANCEL APPOINTMENTS IF THE APPOINTMENT IS NOT CONFIRMED 24 HOURS IN ADVANCE
5. Appointments with **DISCONNECTED PHONE NUMBERS** will be cancelled. Please call to update any changes in phone numbers
6. Please **DO NOT DROP OFF YOUR CHILD** for their appointment. A parent or guardian must be present at all times.

Please feel free to ask any question regarding these policies. Thank you for understanding.

Please Sign _____