

# Lago Vista Family Dentistry

## Patient Information

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Sex: \_\_\_ M \_\_\_ F  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone #: \_\_\_\_\_ Additional #: \_\_\_\_\_ Email: \_\_\_\_\_  
Are any siblings patients of record? If yes, please list their names: \_\_\_\_\_  
Whom may we thank for referring you to our office? \_\_\_\_\_

## Parent/Guardian Information

\_\_\_ Mother \_\_\_ Father \_\_\_ Guardian  
Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work#: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Other #: \_\_\_\_\_

\_\_\_ Mother \_\_\_ Father \_\_\_ Guardian  
Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Employer: \_\_\_\_\_ Work#: \_\_\_\_\_  
Home #: \_\_\_\_\_ Cell #: \_\_\_\_\_ Other #: \_\_\_\_\_

## Insurance Information

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

Dental Insurance? \_\_\_ Yes \_\_\_ No If yes, please fill out the following information:  
Name of person insured: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_  
Insured SSN/ ID#: \_\_\_\_\_ DOB: \_\_\_\_\_ Employer: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Phone #: \_\_\_\_\_ Group #: \_\_\_\_\_

## Dental History

Why is your child here today? \_\_\_\_\_ Is this their first dental visit? \_\_\_\_\_  
If no, date of last dental visit: \_\_\_\_\_ And reason for the visit: \_\_\_\_\_  
Will your child be a cooperative patient? \_\_\_ Yes \_\_\_ No  
Please describe how you think your child will behave today. Check all that apply:  
\_\_\_ Friendly \_\_\_ Happy \_\_\_ Anxious \_\_\_ Timid \_\_\_ Afraid \_\_\_ Resistant  
Does or did your child receive fluoride in any forms? \_\_\_\_\_  
Has your child had any of the following: \_\_\_ Cavities \_\_\_ Crooked teeth \_\_\_ Sensitive to hot/cold \_\_\_ Loose teeth  
\_\_\_ Toothache \_\_\_ Sensitivity to sweets \_\_\_ Frequent headaches \_\_\_ Bad breath  
\_\_\_ Bleeding gums \_\_\_ Discolored teeth  
Does your child have any of the following oral habits? \_\_\_ Thumb sucking \_\_\_ Pacifier use \_\_\_ Lip biting  
\_\_\_ Teeth Grinding \_\_\_ Finger sucking \_\_\_ Excessive lip licking  
How often does your child brush? \_\_\_\_\_ How often does your child floss? \_\_\_\_\_  
At what age did your child stop using the bottle? \_\_\_\_\_ Sippy Cup? \_\_\_\_\_

**Medical History**

Child's Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_

If your child in good health? \_\_\_\_ Yes \_\_\_\_ No

If no, please describe: \_\_\_\_\_

Are your child's immunizations and booster shots up to date? \_\_\_\_ Yes \_\_\_\_ No

Has your child ever been hospitalized or had surgery? \_\_\_\_\_

Is your child taking any kind of medication (prescription or over the counter)? Please list: \_\_\_\_\_

Has your child ever had a reaction to or problem with anesthesia? If yes, please describe: \_\_\_\_\_

Does your child have any drug allergies? If yes, please list: \_\_\_\_\_

Is your child allergic to anything? If yes, please list: \_\_\_\_\_

**Please circle yes or no for any of the following conditions your child has had or now has:**

Complications before during birth/ prematurity	Y/N	Impaired vision, hearing, or speech	Y/N
Syndromes/ Genetic Disorders	Y/N	Convulsions/seizures/ Cerebral Palsy	Y/N
Sinus Problems/ chronic adenoid/tonsil infections	Y/N	Hydrocephaly or placement of shunt	Y/N
Seasonal Allergies	Y/N	ADD/ADHD	Y/N
Asthma	Y/N	Autism Spectrum Disorder/ developmental delays	Y/N
Sleep apnea/snoring/mouth breathing	Y/N	Diabetes	Y/N
Heart trouble	Y/N	Thyroid problems	Y/N
Congenital heart defect/ Heart Murmur	Y/N	Anemia/ blood disorders/ sickle cell disease	Y/N
Rheumatic fever	Y/N	Excessive bleeding	Y/N
High/Low Blood Pressure	Y/N	Blood transfusion	Y/N
Cystic Fibrosis	Y/N	Cancer, tumors, or chemotherapy	Y/N
Frequent colds or coughs, or pneumonia	Y/N	Tuberculosis exposure	Y/N
Jaundice/ Hepatitis/ Liver problems	Y/N	HIV/AIDS	Y/N
Acid reflux disease/Stomach ulcers/ intestinal problems	Y/N	Cleft lip or palate	Y/N
Frequent diarrhea, weight loss, eating disorder	Y/N	Other: _____	
Bladder or kidney problems	Y/N	_____	

**Authorization and Release**

I understand 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 dependent (s), including any balance not paid by my dental insurance company within 30 days of statement date. 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 rental 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 treatment or examination rendered to any child during the period of such dental care to third party payers and or other health practitioners.

Signature of Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Witness: \_\_\_\_\_

**Lago Vista Family Dentistry**

**512-277-3311**

# Lago Vista Family Dentistry

8008 Bronco Lane, Suite B, Lago Vista, TX 78645  
P: 512-277-3311 F: 512-727-7943

## Financial Policy

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to your child and regard your complete understanding of our financial policies as an essential element of care and treatment.

- Payment is due at the time of service unless other arrangements have been made in advance by either yourself or your dental plan coverage. For your convenience, we will accept cash, check, visa, master card, discover and American Express. The **adult accompanying** the child is responsible for payment for services rendered to a child patient.
- Your insurance is a contract between you and your insurance company. As a courtesy, after your first initial visit and upon verification of coverage, we will file your insurance claim for you if you assign the benefits to the doctor; in other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.
- We are contracted with MOST dental insurance plans. If you are covered by one of these plans, we will bill your plan and will only require you to pay your estimated copayment at the time of service. Any remaining balance would be due upon receipt of our statement.
- All dental plans are not the same and do not cover the same services. In the event your dental plan determines a service to be “not covered” or over what they deem “usual and customary charges” you will be responsible for this amount. Payment is due upon receipt of statement from our office. If payment is not made upon receipt of our statement, we will no longer file your insurance. Therefore, we will expect payment in full at the time of service. We do honor some Discount Dental plans so please ask our front office staff to see if we accept your plan.

I have read and understand the financial policy of the practice, and I agree to be bound by its terms.

**Patient's Name:** \_\_\_\_\_

**Signature of Parent or Guardian:** \_\_\_\_\_ **Date:** \_\_\_\_\_

## Consent for Anxiety Reducing Techniques

Please read this form carefully and ask questions about anything you do not understand. Please check each box to identify that you understand this technique.

All efforts will be made to obtain the cooperation of child dental patients by the use of Tell-Show-Do with friendliness, persuasion, humor, charm, gentleness, kindness and understanding. In some cases, further techniques are needed when providing operative care such as fillings, etc. In order to gain cooperation, eliminate disruptive behavior or prevent a patient causing injury to themselves, it may be necessary to use other anxiety reducing techniques.

**Tell-Show-Do:** The dentist or dental team explains to the child what is to be done using simple, kid-friendly terminology and repetition, then shows the child what is to be done by demonstrating with instruments on a model or the child's or the dentist's finger. The procedure is then performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.

**Positive reinforcement:** This technique rewards the child who displays behavior which is desirable with compliments, praise, pat on the back, or a prize.

**Mouth Props/Rubber Dams:** A mouth prop, or tooth pillow as we call it, is used to help support your child in keeping his/her mouth open during an operative procedure (fillings, etc.). This allows him/her to relax and not worry about consciously keeping his/her mouth open for the procedure. A rubber dam is a raincoat placed on the area to be worked on to isolate the teeth, and prevents any debris from being swallowed or from going to the back of the throat.

**Immobilization by dentist:** In the event the child moves unexpectedly (possibly resulting in an unsafe situation) the dentist gently holds the child's hands or upper body, stabilizing the child's head between the dentist's arm and body.

**Immobilization by the assistant:** In the event the child moves unexpectedly (possibly resulting in an unsafe situation) the assistant gently holds the child's hands and stabilizes the child's head and/or legs.

**Relaxation Gas:** Nitrous Oxide (laughing gas) and oxygen may be recommended to relax the child. This allows the child to sit in the chair longer, increases their attention span and allows the treatment to be completed in a comfortable manner for the child.

**Voice Alteration:** A controlled alteration (increase or decrease) of voice, tone, or pace to influence and direct the patient's behavior.

I acknowledge that I have read these statements and agree to the contents.

Signature of Parent or Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

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## Acknowledgement of Receipt of Notice of Privacy Practice

**Notice to Patient: We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice.**

**You may refuse to sign this acknowledgement, if you wish.**

**I acknowledge that I have received a copy of this office's Notice of Privacy Practices.**

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

Please print your name here: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

### FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy from this patient but it could not be obtained because:

- The patient refused to sign.
- Due to an emergency situation it was not possible to obtain an acknowledgement.
- We weren't able to communicate with the patient.
- Other (Please provide specific details)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Employee Signature: \_\_\_\_\_

Date: \_\_\_\_\_

HIPPA Consent for Use / Disclosure of Health Information This form does not constitute legal advice and covers only federal, not state, laws.

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## Authorization – Non-Parent/Guardian to Accompany Patient

Periodically there may be times when you are unable to bring your child to the office for an appointment and need to rely on a family member or friend. We understand these circumstances; however, we must have a written authorization letter allowing this person to accompany your child(ren). The person bringing your child will need to present a photo identification at time of service.

This authorization gives the person permission to bring your child(ren) in, speak to the doctor, given authorization for treatment, medication, certain procedures and make general health decisions.

I, \_\_\_\_\_, give the person(s) listed below permission to bring my child to Red Balloon Dentistry for Children and to discuss and share medical information about my child. I further authorize them to see all necessary medical records and make health care decisions of a routine nature as determined at the sole discretion of the provider. I also give them authority to make more serious or urgent health care decisions in the event I cannot be reached or where it is of an emergency nature where there is not sufficient time to seek out my specific consent.

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Child's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

(IF ONLY PARENTS ARE ALLOWED TO BRING CHILD IN, PLEASE INDICATE 'NONE')

Name of Person (allowed to bring child) \_\_\_\_\_ Relationship \_\_\_\_\_

Name of Person (allowed to bring child) \_\_\_\_\_ Relationship \_\_\_\_\_

Name of Person (allowed to bring child) \_\_\_\_\_ Relationship \_\_\_\_\_

Please print your name here: \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

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## Appointment Consent

I attest that the information I have provided on this form is correct to the best of my knowledge. I understand that providing incorrect information can be dangerous to my child's health. It is my responsibility to inform the dental office on any changes in my child's medical status.

I understand that signing below I authorize the following procedures to be performed as deemed necessary by the dentist and have read and understand the possible risks and complications of each procedure.

### X-rays and Examination

I understand that my child will be receiving a dental examination from a state licensed dentist. I understand that x-rays may be taken of my child's teeth as part of the necessary requirements to complete a thorough and comprehensive examination.

### Medical Photography Consent

I consent to digital photographs and x-ray images of my child to be used exclusively within their medical record for the purpose of identification and dental treatment.

### Dental Cleaning and Fluoride Treatment

I authorize Lago Vista Family Dentistry and their staff members to clean my child's teeth today. I understand that the application of fluoride is part of the standard of care for children and helps to prevent cavities.

### Drugs and Medication

I understand that antibiotics, analgesics and topical compounds can cause allergic reactions even with no prior known history. Allergic reactions can cause redness and swelling of tissues, pain, itching, vomiting, and/or anaphylactic shock. I have informed the dentist, to the best of my knowledge, of any adverse reactions my child has had.

**I understand that all of the above treatments are the standard of care in dentistry. It is my responsibility to inform the staff during the registration process if I choose to decline any of the above treatments.**

### Optional Photography Consent

I consent to having my child's photo taken and displayed in the office as part of contests or bulletin boards.

I consent       I do not consent

I consent to having my child's photo taken and posted as part of online social media including, but not limited to: the office website, Facebook and Google.

I consent       I do not consent

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

Time: \_\_\_\_\_

Signature of Parent or Guardian: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Witness: \_\_\_\_\_

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