PATIENT REGISTRATION AND MEDICAL HISTORY

Welcome to Star Smiles Pediatric Dentistry. We would like to welcome you and your child to our dental office. Our primary goal is to make every visit fun and educational for your child.

ABOUT YOUR CHILD

Patient's Name _____ Date of Birth _____ ☐ Male ☐ Female

Home Address _____ Home Phone _____

City _____ State _____ Zip Code _____

How did you hear about our office? ☐ Friend/ Dr. Referral_____

☐ School Folder ☐ Billboard ☐Baseball Fields ☐ Cupid's 5K Run ☐ Community Impact
☐ School Presentation ☐ Insurance Company ☐ Website Search ☐ Healthcare Directory
☐ Georgetown View ☐ Facebook ☐ Other _____

PERSON RESPONSIBLE FOR ACCOUNT

MOTHER'S/GUARDIAN INFORMATION

email address_____

Name _____ D.O.B. _____

Address _____ City, State, Zip _____

Employer _____ Social Security _____

Home Phone _____ Work Phone _____ Cell Phone _____

FATHER'S INFORMATION

email address _____

Name _____ D.O.B. _____

Address _____ City, State, Zip _____

Employer _____ Social Security _____

Home Phone _____ Work Phone _____ Cell Phone _____

⭐Star Smiles Pediatric Dentistry⭐

Medical History

Patient Name _____

What are your primary concerns about your child's oral health?_____

Has your child had any of the following conditions?

Yes	No		Yes	No	
☐	☐	Anemia	☐	☐	Autism Spectrum Disorder (Severe or Mild)
☐	☐	Heart Condition – Please Explain	☐	☐	Delayed Development (approx. age function:)
☐	☐	Rheumatic Fever or Scarlet Fever	☐	☐	Sexually Transmitted Disease _____
☐	☐	Hearing Impairment	☐	☐	Cancer Malignancy, Leukemia or Lymphoma
☐	☐	Thyroid Disorder	☐	☐	Hepatitis or Jaundice (date:)
☐	☐	Currently Pregnant	☐	☐	Seizures, Epilepsy or Convulsions
☐	☐	Asthma or Lung Problems	☐	☐	Diabetes (NIDDM or IDDM)
☐	☐	Tobacco, Alcohol or Drug Use	☐	☐	Emotional, Behavioral or Psychiatric Problems
☐	☐	Ear Infection(s) / Otis Media	☐	☐	Disabilities or Handicaps
☐	☐	Bruise or Bleeds Easily	☐	☐	Diagnosed with ADD, ADHD, or Hyperactivity
☐	☐	Cleft Lip/ Palate	☐	☐	Implanted Shunts, Pins, Screws or Rods
☐	☐	Learning Disability	☐	☐	Congenital Birth Defects / Syndrome
☐	☐	Seasonal Allergies, Hay Fever etc	☐	☐	Kidney/Liver Disease or Transplant
☐	☐	Latex Allergy or Sensitivity	☐	☐	Stomach/ GI Disorder
☐	☐	Physical or Emotional Abuse	☐	☐	Tuberculosis or Previous Positive Test

Has your child had the DPT immunization series for diphtheria, pertussis, & tetanus? ☐Yes ☐No

Has your child been hospitalized for any reason?

Reason for Hospitalization(s):_____Date(s):_____

Has your child had any surgeries?

Type of Surgery:_____Date(s):_____

Is your child currently taking any medications? ☐Yes ☐No If so, please list_____

Is your child allergic or has your child ever had an adverse reaction to a specific medication? ☐Yes ☐No

If so which medication? _____

Is your child currently under the care of a physician? ☐Yes ☐No If so, for what_____

Please list the names and phone numbers of any treating physicians.

Type of Physician	Physician Name	Office Phone Number
Pediatrician		

Dental History

Has your child ever suffered from any of the following problems? Please circle.

Yes	No		Yes	No	
☐	☐	Bad breath/ Halitosis	☐	☐	Popping or Soreness of Jaws
☐	☐	Bleeding Gums	☐	☐	Dental Infection or Abscess
☐	☐	Stained or Discolored Teeth	☐	☐	Pain from Teeth
☐	☐	Cold Sores or Fever Blisters	☐	☐	Missing or Extra Teeth
☐	☐	Dry Mouth	☐	☐	Injury or Trauma to Teeth, Mouth or Face
☐	☐	Dental Anxiety			If so please explain
☐	☐	Does your child receive fluoride supplementation?			
☐	☐	Does your child brush daily?			
☐	☐	Does your child suck a thumb, finger or pacifier?			

How would you describe your child's current oral health? ☐Excellent ☐Good ☐Fair ☐Poor

How would you predict your child's behavior to be? ☐Cooperative ☐Fearful ☐Defiant ☐Don't know

DENTAL INSURANCE INFORMATION

Primary Insurance Company Name:
Insurance Company Phone Number:
Policy Holder Name:
Date of Birth:
Employer Name:
Group Number:
ID Number:
Social Security Number:

MEDICAL/DENTAL RELEASE STATEMENT

I give my consent for the doctor of Star Smiles Pediatric Dentistry to do a complete and thorough examination on the patient previously named, including any diagnostic radiographs needed. To the best of my knowledge, the information that I have given is correct and I understand that it will be held in the strictest of confidence. Furthermore, I understand that it is my responsibility to inform Star Smiles Pediatric Dentistry of any future changes to my child's medical status.

_____ Initial

REQUIREMENT FOR FILING INSURANCE CLAIMS

To expedite the filing of my dental insurance claims, I do hereby authorize the release of confidential information to my dental insurance agency. I hereby authorize payment of insurance benefits directly to Star Smiles Pediatric Dentistry.

_____ Initial

_____ _____

PARENT OR LEGAL GUARDIAN SIGNATURE DATE

⭐Star Smiles Pediatric Dentistry⭐

Financial and Insurance Policy

We are pleased to welcome you to our practice. Our desire is to provide you with the highest quality dental care in a caring and fun atmosphere for your child. It is our policy to make definite financial arrangements with you prior to any treatment. Below is an explanation of our payment procedures. If you have any questions, please do not hesitate to ask.

1. Payment for services is due at the time services are rendered. We accept cash, checks, and credit cards (VISA, Mastercard, American Express, Discover, and Care Credit).

2. As a courtesy, we will file your insurance for you and accept assignment of benefits. In some cases, insurance companies will not accept assignment of benefits to out of network providers. In this case, you will be responsible for payment in full at the time of service. We will still file the insurance for you, and your insurance will send you payment.

3. If the claim is not paid by your insurance carrier within 60 days, you will be responsible for the full balance as well as any insurance appeals for that claim. We will be happy to provide you with a claim form so that you can follow up on your insurance claims personally.

4. You must provide the office with your dental insurance information prior to your appointment so the information can be verified and updated on your account. If at the time of your appointment you provide us with new insurance information, you will be responsible for payment of all fees. We will verify the insurance and file it for you within 48 hours of the appointment, and you will be reimbursed for what your insurance pays.

5. If insurance benefits are assigned to the doctor, you will be responsible for paying your deductible and co-payments at the time of service. We will provide you with an estimate of any treatment prior to scheduling your next visit. After 90 days of diagnosis this estimate may be subject to change of fees as well as treatment. Your insurance benefits are a contract between you and your employer. The amount of coverage you will receive will depend on the plan purchased by your employer, not the fees of the doctor, therefore we cannot provide an exact benefit amount without a predetermination. After final payment from your insurance company is received, we will send you a final statement of any remaining balance.

6. The office will not carry balances longer than 90 days; regardless if the insurance payment is still pending. A finance charge of 1.5% will be added to your account if it is not paid in full within 90 days and is greater than $20.

7. We will send weekly statements to notify you of any balance. If the account remains unpaid after the 90 day period. This office will be required to employ a collection service or seek legal action to collect payment. The responsible party agrees to pay all reasonable, related collection fees.

8. There will be a $40.00 service charge for all returned checks. If the returned check is not paid for within 30 days, it will be sent to the Williamson County District Attorney's Office.

9. The parent or guardian who signs the 'Financial and Insurance Policy' is ultimately responsible for payment, independent of what a divorce decree may state. Reimbursement must be made between the divorced parents. We will not intervene.

AUTHORIZATION

I have read, understand and agree to the terms set forth in the above Financial and Insurance Policy.

_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

3614 Williams Dr. ⭐ Georgetown, TX 78628 ⭐ (512) 864-9595

LEGAL CONSENT TO MAKE DECISIONS

PATIENT'S NAME_____

As a convenience, we would like to offer you a chance to provide Star Smiles Pediatric Dentistry, Dr. Kelly M. Gonzales and her staff, with a list of individual(s) that may accompany your child to subsequent visits. Listing an individual will automatically provide them with your legal consent to make both treatment and financial decisions on your behalf.

With this list, a family member, stepparent, or good friend would have the authority to accompany your child to the dental appointment and make decisions without the need of any additional written or oral consent. If not listed, patients must always be present with a parent or legal guardian. Please only provide the names of those individuals that you trust to make medical and financial information decisions.

As a HIPAA compliant healthcare facility, we will use our best discretion to maintain all personal information and will only provide the individuals listed below with information needed to make a specific decision on your behalf. Information will only be provided on a need-to-know basis and we will not allow these individuals to have a copy of your child's dental records. We simply want to make treating your child in our facility as convenient as possible for you.

Please identify such individuals that you are allowing to provide consent or make treatment decisions. This individual must be at least 18 years of age.

CONSENT TO MAKE DECISIONS

Individual's Name (must be 18 or older)	Relationship

As parent or legal guardian of the patient noted above, I do hereby provide the individuals listed beneath the chart entitled "Consent to Make Decisions", the legal authority to make decisions in my absence. I also understand that these decisions may change or alter previous treatment recommendations or charges that I have already agreed to and that I as this child's parent or legal guardian, am ultimately responsible for any new charges incurred as a result of treatment decisions made by any individual listed above.

_____ _____

SIGNATURE OF PARENT OR LEGAL GUARDIAN DATE

CONSENT STATEMENTS

PATIENT'S NAME _____

The following consent statements refer to documents containing information regarding specific policies of Star Smiles Pediatric Dentistry. Please sign these statements only after carefully reading such information. These informative documents should be retained for future reference.

FINANCIAL AND INSURANCE INFORMATION

I have read the form entitled "Financial and Insurance Policy" . I understand that the parent or legal guardian who accompanies my child to an appointment will be responsible for payment at the time services are rendered, unless prior arrangements have been made.

_____ _____

Parent or Legal Guardian Signature Date

STAR SMILES PEDIATRIC DENTISTRY APPOINTMENT POLICY

I have read and understand the form entitled "Appointment Policy". Furthermore, I take full responsibility for the cancellation of any appointments and am aware that without proper notification or a valid reason, a $25 fee will be incurred.

_____ _____

Parent or Legal Guardian Signature Date

NOTICE OF PRIVACY PRACTICES

Health Insurance Portability & Accountability Act of 1996

I have read and understand the form entitled "Notice of Privacy Practices" concerning the privacy of my child's confidential healthcare information. I do hereby provide consent for the standard use of such information and understand that these provisions prohibit Star Smiles Pediatric Dentistry from selling or transferring this information to any unauthorized location without my prior approval. I have reviewed this information and all questions have been answered to my satisfaction.

_____ _____

Parent or Legal Guardian Signature Date

FOR OFFICE USE ONLY

I attest that the following documents were provided to the parent or legal guardian of the child noted above. All questions have been answered, and I have witnessed the signing of these consent statements.

Witness Signature Date