Dear Parents,

Hi, I'm Dr. Scott Furrow, a Board Certified Pediatric Dentist, and I would like to welcome you to Leander Pediatric Dentistry. Children bring with them energy and excitement and are full of life and surprises. I know that how I treat each child will have a major influence on their perception of dentistry and I know that I can make it a positive memory. My team is dedicated to helping provide children with the necessary building blocks for creating a positive dental attitude. Below is information that you may find helpful in preparing for the first visit to our office.

PRIOR TO YOUR CHILD'S FIRST VISIT- We will contact you with instructions for completing paperwork necessary for treatment of your child. By completing most paperwork in advance, it allows both our patients and their parents to experience what it is that sets our office apart.

THE FIRST VISIT AND OUR POLICY- Before the age of 3 years, we ask that parents accompany their children during their entire dental visit. Our dental experience has shown that after this age, most patients excel by visiting the clinical area with their new found friends…patients and staff, with the parents in the reception area. By looking to us for interaction rather than their parents, this opportunity builds their self-esteem and confidence since they become proud of their independence. In addition to developing a relationship with myself and my team, the patients quickly realize that Leander Pediatric Dentistry is one of the rare places that your child can truly call their own. Although this is usually the best experience as a rule of thumb, parents are allowed in the clinic and I enjoy visiting with parents as well. We know that your child's first visit to the dentist is a very important milestone and we are confident that choosing Leander Pediatric Dentistry is a great decision!

Sincerely,

Dr. Scott

PATIENT REGISTRATION

Responsible Party(parent or legal guardian who will be coming to the first appointment)

First Name: ___________________________________ Last Name: _____________________________ Middle Initial: _______
Home Address: ____
City, State, Zip: ____ Page: ___________________
Home Phone: __________________________Work Phone: _________________Ext: _____________ Cellular: ______________
Birth date: _____________________ Soc Sec: _____________________________ Drivers Lic: _________
E-mail: _________________________ ☐ I would like to receive correspondence via e-mail

☐ Responsible Party is the primary insurance policy holder for the Patient

☐ Responsible Party is the secondary insurance policy holder for the Patient

Patient Information

Address: ____ Address 2: ______________________________________
City: ____________________________ __________State / Zip: __________________________________ Pager: ______________
Home Phone: ________________________Work Phone: ____________________ Ext: ______________ Cellular: ____________
Sex: ◯ Male ◯ Female
Birth date: ____________________________ Referred By: ____________________
How did you hear about us?
◯ From Friend ◯ Community Event ◯ Newspaper ◯ Mail Out ◯ Drive By
Previous Dentist: _________________ Emergency Contact: _______________ Emergency Contact #: ______________

Primary Insurance information

Name of Policy Holder:

First Name: ___________________________________ Last Name: _____________________________ Middle Initial: _______
Policy Holder's Soc. Sec: _______________________________
Policy Holder's Birth Date: ____ Employer: __________________________
Policy Holder's Home Address: ____
City, State, Zip: ____
Home Phone: __________________________Work Phone: _________________Ext: _____________ Cellular: ______________
Insurance Company: ____
Employer/Group #: ______________________________ Carrier/Member ID: _______________________
Claims Phone: ____________________________ Claims Submission Address: _______________________

Secondary Insurance information

Name of Policy Holder:

First Name: ___________________________________ Last Name: _____________________________ Middle Initial: _______
Policy Holder's Soc. Sec: _______________________________
Policy Holder's Birth Date: ____ Employer: __________________________
Policy Holder's Home Address: ____
City, State, Zip: ____
Home Phone: __________________________Work Phone: _________________Ext: _____________ Cellular: ______________
Insurance Company: ____
Employer/Group #: ______________________________ Carrier/Member ID: _______________________
Claims Phone: ____________________________ Claims Submission Address: _______________________

MEDICAL HISTORY

Patients Name ____________________

Date of Birth ____________________ ________

Although dental personnel primarily treat the area in and around your mouth, your mouth is a part of your entire body. Health problems that you may have, or medication that you may be taking, could have an important interrelationship with the dentistry you will receive. Thank you for answering the following questions.

Are you under a physician's care now? Yes No If yes, please explain: ____________________

Have you ever been hospitalized or had a major operation? Yes No If yes, please explain: ____________________

Have you ever had a serious head or neck injury? Yes No If yes, please explain: ____________________

Are you taking any medications, pills, or drugs? Yes No If yes, please explain: ____________________

Do you take, or have you taken, Phen-Fen or Redux? Yes No ____________________

Have you ever taken Fosamax, Boniva, Actonel or any other medications containing bisphosphonates? Yes No ____________________

Are you on a special diet? Yes No

Do you use tobacco? Yes No

Do you use controlled substances? Yes No

Women: Are you

Pregnant/Trying to get pregnant? Yes No Taking oral contraceptives? Yes No Nursing? Yes No

Are you allergic to any of the following?

Aspirin Penicillin Codeine Local Anesthetics Acrylic Metal Latex Sulfa drugs

Other If yes, please explain: ____________________

Do you have, or have you had, any of the following?

AIDS/HIV Positive	Yes	No	Cortisone Medicine	Yes	No	Hemophilia	Yes	No	Radiation Treatments	Yes	No
Alzheimer's Disease	Yes	No	Diabetes	Yes	No	Hepatitis A	Yes	No	Recent Weight Loss	Yes	No
Anaphylaxis	Yes	No	Drug Addiction	Yes	No	Hepatitis B or C	Yes	No	Renal Dialysis	Yes	No
Anemia	Yes	No	Easily Winded	Yes	No	Herpes	Yes	No	Rheumatic Fever	Yes	No
Angina	Yes	No	Emphysema	Yes	No	High Blood Pressure	Yes	No	Rheumatism	Yes	No
Arthritis/Gout	Yes	No	Epilepsy or Seizures	Yes	No	High Cholesterol	Yes	No	Scarlet Fever	Yes	No
Artificial Heart Valve	Yes	No	Excessive Bleeding	Yes	No	Hives or Rash	Yes	No	Shingles	Yes	No
Artificial Joint	Yes	No	Excessive Thirst	Yes	No	Hypoglycemia	Yes	No	Sickle Cell Disease	Yes	No
Asthma	Yes	No	Fainting Spells/Dizziness	Yes	No	Irregular Heartbeat	Yes	No	Sinus Trouble	Yes	No
Blood Disease	Yes	No	Frequent Cough	Yes	No	Kidney Problems	Yes	No	Spina Bifida	Yes	No
Blood Transfusion	Yes	No	Frequent Diarrhea	Yes	No	Leukemia	Yes	No	Stomach/Intestinal Disease	Yes	No
Breathing Problem	Yes	No	Frequent Headaches	Yes	No	Liver Disease	Yes	No	Stroke	Yes	No
Bruise Easily	Yes	No	Genital Herpes	Yes	No	Low Blood Pressure	Yes	No	Swelling of Limbs	Yes	No
Cancer	Yes	No	Glaucoma	Yes	No	Lung Disease	Yes	No	Thyroid Disease	Yes	No
Chemotherapy	Yes	No	Hay Fever	Yes	No	Mitral Valve Prolapse	Yes	No	Tonsillitis	Yes	No
Chest Pains	Yes	No	Heart Attack/Failure	Yes	No	Osteoporosis	Yes	No	Tuberculosis	Yes	No
Cold Sores/Fever Blisters	Yes	No	Heart Murmur	Yes	No	Pain in Jaw Joints	Yes	No	Tumors or Growths	Yes	No
Congenital Heart Disorder	Yes	No	Heart Pacemaker	Yes	No	Parathyroid Disease	Yes	No	Ulcers	Yes	No
Convulsions	Yes	No	Heart Trouble/Disease	Yes	No	Psychiatric Care	Yes	No	Venereal Disease	Yes	No
									Yellow Jaundice	Yes	No

Have you ever had any serious illness not listed above? Yes No ____________________

Comments: ____________________

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 (or patient's) health. It is my responsibility to inform the dental office of any changes in medical status.

SIGNATURE OF PATIENT, PARENT, or GUARDIAN ____________________ DATE ____________

PRINTED NAME OF PARENT OR GUARDIAN ____________________

LEANDER PEDIATRIC DENTISTRY OFFICE AND FINANCIAL POLICY

Thank you for choosing our office as your dental health care provider. We are committed to providing you with the highest quality of dental care so that you may fully attain optimum oral health. Everyone benefits when office and financial policy arrangements are understood. In order that we may have a definite understanding in regard to the payment for dental services, the following is our policy.

Payment is due at the time service is provided. We accept cash, personal checks, cashier's checks, money orders, Visa, MasterCard, and Care Credit. Returned checks will be subject to additional fees.

Patients who carry dental insurance understand that all dental services furnished are charged directly to the patient and that he or she is personally responsible for payment of all dental services regardless of dental insurance. As a courtesy to you we will help you process all your insurance claims. We ask that you pay the deductible and co-payment, which is the **estimated** amount not covered by your insurance company at the time we provide service to you. We must emphasize that this is only an **estimate** and all charges you incur are your responsibility regardless of your insurance coverage. Insurance companies have a wide variety of rules, plan limitations and exclusions that our office may not be aware of. Dental insurance is a benefit for the patient provided by an employer and the contract lies between the patient, employer and the insurance company. Our office is not a party to that contract. We will cooperate fully with the regulations and requests of your insurance company that may assist in the claim being paid. However, this office will not enter into a dispute with your insurance company over any claim. Once insurance has paid their share, a statement will be sent to you for any remaining balance and will be due upon receipt. If your insurance company has not made payment within 60 days, the unpaid balance becomes your responsibility and is subject to finance charges and the collection process.

Separated & Divorced Couples with Dependent Children: It is the policy of this office to bill the parent that brings the children in for their dental treatment. Please make arrangements for payment from an ex-spouse before dental treatment is rendered. We can provide a treatment cost estimate before your scheduled appointment.

All Patients must provide an **ID Card & Insurance Card** (if applicable) to be copied at the time of the appointment. We also require home and work telephone numbers, as well as a contact number to use in case of emergency.

Cancellation & Late Policy: Your appointment time is reserved for you. If you are late for your appointment, we may not be able to accommodate you. If you think that you will be late, please call as soon as possible so that we may advise you if your late arrival can be accommodated, or if we will need to reschedule you. We maintain a very strict schedule and must insist that appointment times be respected. For cancellation we require 24 hours advanced notice. An answering machine is available for messages left after business hours. Three missed appointments may result in dismissal as a patient.

We thank you for the opportunity to serve your dental health care needs and welcome any questions you may have concerning your care or our policies. *Significant costs are incurred in carrying our patients' accounts. To control these costs and help keep fees down, it is necessary to adhere to these policies.*

CONSENT: I HAVE READ, UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS. I AUTHORIZE MY INSURANCE COMPANY TO PAY MY DENTAL BENEFITS DIRECTLY TO MY DENTAL OFFICE. The undersigned hereby authorizes Doctor to take X-rays, study models, photographs, or any other diagnostic aids deemed appropriate by Doctor to make a thorough diagnosis of the patient's dental needs. I also authorize Doctor to perform any and all forms of treatment, medication and therapy that may be indicated. I also understand the use of anesthetic agents embodies a certain risk. I understand that responsibility for payment for Dental Services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered. I further understand that a finance, rebilling, collection charge or attorney fee will be added to any overdue balance.

_______________________________ _______________

Signature (Patient or responsible party) Date

HIPPA Consent Form

The federal government requires all medical offices to make patients aware that they have rights regarding the use of their personal health information. Our notice of privacy practices is available for your review at the front desk.

By signing this form, I consent to Leander Pediatric Dentistry's use and disclosure of protected health information according to the Notice of Privacy Practices available to me at our front desk.

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

•Treatment (including direct or indirect treatment by other healthcare providers involved in my treatment).

•The day to day healthcare operations of your practice.

•I have also been informed of, and given the rights to review and secure a copy of your Notice of Privacy Practices which contains a more complete description of the use and disclosures of my protected health information, and my rights under HIPAA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

•I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these request restrictions.

•However, if you do agree, you are bound to comply with this restriction. I understand that I may revoke this consent at any time, in writing, signed by you.

The Patient understands that:

•We will not release information to any future doctor, attorney, life insurance company, or workman's company without your written consent.

•Protected health information may be used for treatment through one of your current doctors (such as your primary care physician or a specialist referral), payment with your insurance company, or healthcare operations within our office.

•Leander Pediatric Dentistry reserves the right to change the notice of privacy practices.

•The patient has the right to restrict the use of their information, but Leander Pediatric Dentistry may not have to agree to these restrictions if, for example, it interferes with payment, daily operations, or providing quality health care.

•The patient may revoke this consent in writing at any time and all future disclosures will then cease.

Leander Pediatric Dentistry may condition treatment upon the execution of this consent (for example, you may be required to pay your visit at the time of service)

Relationship to Patient________________________

Signature________________________ Date ____________