DR. SUSAN ROBERTS
PEDIATRIC DENTISTRY
www.susanrobertsdentistry.com
817-656-3999

Welcome!

We are pleased to welcome you and your child to our practice.

Patient Information

PLEASE FILL OUT FRONT AND BACK SIDE

Email _____ Birthdate _____ Age _____

Patient Name _____ Sex ☐ M ☐ F
Last Name First Name Middle Initial

Nickname _____ Primary Phone # _____ School Name _____

Home Address _____
Street City State Zip

Whom may we thank for referring you? _____

Person Financially Responsible _____ Home Phone _____ Work Phone _____

Father's/Guardian's Name _____
Mailing Address _____

Cell Phone _____ Work Phone _____
Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for min/child? ☐ Yes ☐ No
Plan Name _____ Phone _____
Address _____
Group # _____ Policy # _____
Employer _____

Mother's/Guardian's Name _____
Mailing Address _____

Cell Phone _____ Work Phone _____
Soc. Sec. # _____ Birthdate _____

Do you have dental insurance coverage for min/child? ☐ Yes ☐ No
Plan Name _____ Phone _____
Address _____
Group # _____ Policy # _____
Employer _____

Dental History

Date of last visit to a dentist _____ For what service? _____

	Yes	No
Has child complained about dental problems?	☐	☐
Does child brush teeth daily?	☐	☐
Does child use floss every day?	☐	☐

	Yes	No
Is fluoride taken in any form?	☐	☐
Any injuries to mouth, teeth, head?	☐	☐
Any unhappy dental experiences?	☐	☐

Please list details _____

Any mouth habits—thumb sucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc.? _____

Medical History

Name of Patient's Physician_____
Date of last physical examination:_____
Is patient under care of a physician now?
Taking any medication or drugs?_____
Has patient ever been hospitalized?
Has patient ever had surgery?_____

City/State _____ Phone _____
Results _____
Medications _____
Reason for Medication _____
_____
Allergies _____

Is there history of excessive bleeding when cut? _____

Has patient had any history of or difficulty with any of the following? If yes, please check:

☐ AIDS/HIV	☐ Cerebral Palsy	☐ Epilepsy	☐ Hepatitis	☐ Mumps
☐ Anemia	☐ Chicken Pox	☐ Fainting	☐ Kidney Disease	☐ Rheumatic Fever
☐ Asthma	☐ Convulsions	☐ Hearing Problems	☐ Liver Disease	☐ Sinus Problems
☐ Bladder Problems	☐ Diabetes	☐ Heart Problems	☐ Measles	☐ Thyroid Disease
☐ Cancer	☐ Drug/Alcohol Abuse	☐ Heart Murmur	☐ Mononucleosis	☐ Tuberculosis
☐ Any adverse reaction to any anesthetic (Novicane)			☐ Latex Allergy	
☐ Other / ADHD or Autism (PLEASE SPECIFY)				

Emergency Contact

In the event of an emergency,

whom should we contact?

Name _____ Relationship _____ Phone _____

Name _____ Relationship _____ Phone _____

Authorizations

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if my minor child ever has a change in health.

Minor/Child Consent
I am the parent, guardian, or personal representative of _____
(Please print name of minor/child)
and there are no court orders now in effect that prohibit me from signing this consent. I do hereby request and authorize the dental staff to perform necessary dental services for the child named above, including but not limited to X-rays and administration of anesthetics, which are deemed advisable by the doctor, whether or not I am present when the treatment is rendered.

Insurance Assignment and Release
I certify that my dependent(s) is/are covered by insurance with _____
(Name of Insurance company)
and assign directly to Dr. _____ all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions.

The above-named doctor may use my minor/child's health care information and may disclose such information to the above-named Insurance Company(ies) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services. This consent will end when the current treatment plan is completed or one year form the date signed.

_____ _____
Signature of Parent, Guardian or Personal Representative — Date

_____ _____
Please print name of Parent, Guardian or Personal Representative — Relationship to Patient

Would you like to give consent to someone other than yourself (parent/guardian) to bring your child to their dental appointments? ☐ Yes ☐ No
If yes, please indicate whom and their relationship to your child.

_____

Is it okay to send text or email reminders of future appointments? ☐ Yes ☐ No

Date _____ Parent/Guardian Signature _____

Date _____ Dentist Signature _____

Dr. Susan Roberts Pediatric Dentistry
5411 Basswood Blvd Suite 201, Fort Worth TX 76137 _ 12485 Timberland Blvd Suite 703, Fort Worth TX 76244

THIS FORM WILL BE USED FOR ALL CHILDREN IN FAMILY FILE

AUTHORIZATION TO TREAT FORM

_____
Name of Patient **(Please list each child's name)**

I authorize Dr. Susan Roberts to perform a complete dental examination, dental prophylaxis (clean the teeth), topical fluoride application, and necessary radiographs. (Parent to be informed before X-rays are taken.)

_____ _____
Signed Date

_____
Name of Patient **(Please list each child's name)**

I authorize Dr. Susan Roberts to treat the above mentioned patient using restorative or oral surgery techniques as well as patient management techniques that are reasonable and necessary as the doctor deems advisable, including the use of nitrous oxide (laughing gas). I understand that the treatment plan presented, along with the fees outlined, could change depending upon the time elapsed since the examination and extent of decay.

_____ _____
Signed Date

Dr. Susan Roberts Pediatric Dentistry
5411 Basswood Blvd Suite 201, Fort Worth TX 76137 - 12485 Timberland Blvd Suite 703, Fort Worth TX 76244

THIS FORM IS TO ACKNOWLEDGE THAT OUR OFFICE HAS PROVIDED YOU WITH HIPPA PRIVACY INFORMATION

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement

I, _____, have received a copy of this office's Notice of Privacy Practices.

_____
Please Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

_____
_____
_____
_____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about our privacy practices, our legal duties, and your rights concerning your health information. We must follow the privacy practices that are described in this Notice while it is in effect. This Notice takes effect on April 28, 2003, and will remain in effect until we replace it.

We reserve the right to change our privacy practices and the terms of this Notice at any time, provided such changes are permitted by applicable law. We reserve the right to make the changes in our privacy practices and the new terms of our Notice effective for all health information that we maintain, including health information we created or received before we made the changes. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available upon request.

You may request a copy of our Notice at any time. For more information about our privacy practices, or for additional copies of this Notice, please contact us using the information listed at the end of this Notice.

USES AND DISCLOSURES OF HEALTH INFORMATION

We use and disclose health information about you for treatment, payment, and healthcare operations. For example:

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Your Authorization: In addition to our use of your health information for treatment, payment or healthcare operations, you may give us written authorization to use your health information or to disclose it to anyone for any purpose. If you give us an authorization, you may revoke it in writing at any time. Your revocation will not affect any use or disclosures permitted by your authorization while it was in effect. Unless you give us a written authorization, we cannot use or disclose your health information for any reason except those described in this Notice.

To Your Family and Friends: We must disclose your health information to you, as described in the Patient Rights section of this Notice. We may disclose your health information to a family member, friend or other person to the extent necessary to help with your healthcare or with payment for your healthcare, but only if you agree that we may do so.

Persons Involved In Care: We may use or disclose health information to notify, or assist in the notification of (including identifying or locating) and family member, your personal representative or another person responsible for your care, of your location, your general condition, or death. If you are present, then prior to use or disclosure of your health information, we will provide you with an opportunity to object to such uses or disclosures. In the event of your incapacity or emergency circumstances, we will disclose health information based on a determination using our professional judgment disclosing only health information that is directly relevant to the person's involvement in your health care. We will also use our professional judgment and our experience with common practice to make reasonable inferences of your best interest in allowing a person to pick up filled prescriptions, medical supplies, x-rays, or other similar forms of health information.

Marketing Health-Related Services: We will not use your health insurance information for marketing communications without your written authorization.

Required by Law: We may use or disclose your health information when we are required to do so by law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. We may disclose your health information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

National Security: We may disclose to military authorities the health information of Armed Forces personnel under certain circumstances. We may disclose to authorized federal officials health information required for lawful intelligence, counterintelligence, and other national security activities. We may disclose to correctional institution or law enforcement official having lawful custody of protected health information of inmate or patient under certain circumstances.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders (such as voicemail messages, postcards, or letters).

PATIENT RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. (You must make a request in writing to obtain access to your health information. You may obtain a form to request access by using the contact information listed at the end of this Notice. We will charge you a reasonable cost-based fee for expenses such as copies and staff time. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies, we will charge you $20.00 for each page, $30.00 per hour for staff time to locate and copy your health information, and postage if you want the copies mailed to you. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. If you prefer, we will prepare a summary or an explanation of your health information for a fee. Contact us using the information listed at the end of this Notice for a full explanation of our fee structure.)

Disclosure Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain other activities, for the last 6 years, but not before April 14, 2003. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests.

Restriction: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but it we do, we will abide by our agreement (except in an emergency).

Alternative Communication: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. (You must make your request in writing.) Your request must specify the alternative means or location, and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Electronic Notice: If you receive this Notice on our Web site or by electronic mail (e-mail), you are entitled to receive this Notice in written form.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us.

If you are concerned that we may have violated your privacy rights, or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use or disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may complain to us using the contact information listed at the end of this Notice. You also may submit a written complaint with the U.S. Department of Health and Human Services upon request.

We support your right to the privacy of your health information. We will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

email: OCRComplaint@hhs.gov

online: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf

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Office Policy Regarding Broken Appointments and Insurance

Our administrative team understands dental insurance and will be happy to assist you in obtaining the maximum benefits specified in your contract. However, it is important that you realize the following information.

1. **There will be a $25.00 charge for missed or canceled appointments if you do not provide us with a minimum of a 24-hour notice. Violation of our Broken Appointment policy may result in requiring payment in advance for dental services or refusal to treat in our office.**

2. If you are running more than 10 minutes late to your dental appointment it is highly recommended that you contact our office immediately. Running late to your scheduled dental appointment may result in appointments being rescheduled or longer wait times.

3. Your dental benefit program is a contract between you, your employer, and the insurance company. Our office files your primary insurance as a courtesy to you but we **do not file secondary** insurance.

4. Guarantors are responsible for being aware of their **own eligibility and dental insurance coverage.**

5. Our fees, generally, but not necessarily, fall within the usual and customary fee structure determined by your carrier.

6. Not all dental services are a covered benefit. We will try to determine this before dental treatment is performed. However, there is no guarantee until actual payment has been received from your insurance carrier.

7. Fluoride treatments are highly recommended and given every 6 months at routine cleanings. Please be advised that some insurance companies only cover this procedure once per calendar year. If you do not wish to have this service performed, please let us know in advance.

8. X-rays are taken at the first visit if your child is over the age of 3. It is your responsibility to tell **us if x-rays have already been taken at another office within the past 6 months**. Bitewing x-rays are taken once a year along with occlusal x-rays. Please be aware that some insurance companies do not always pay **for x-rays at 100% and you may have a coinsurance portion if these x-rays are taken**.

9. You are ultimately responsible for all charges incurred in our office unless otherwise stated by a preferred provider insurance company.

10. A coinsurance estimate will be given to you if your child needs dental treatment. This estimate will provide you with the dental benefits that your insurance company is anticipated to pay based on the information they have provided us. **Your coinsurance portion and deductible will be due at the time the services are rendered**. Please understand we can only provide an estimate of the amount we anticipate your dental insurance will pay.

11. We ask parents to remain in the office during your child's appointment but especially during dental treatment.

I understand that I am responsible for all fees incurred and agree to pay any amount not paid by my insurance carrier.

_____

Signature of parent or guardian Date