619 S. Heatherwilde Blvd. • Pflugerville, Texas 78660 • 512-989-6900 • www.drbainpediatricdentist.com

Date_____ SS# _____ Birthdate _____

Name of Minor/ Child_____ Sex □ M □ F Age_____

Nickname_____ Hobbies_____ Cell Phone (___) _____

Home Address_____City_____State_____ Zip_____

School Name_____School Phone_____

Person Financially responsible _____Home Phone (___) _____

*Whom may we thank for referring you? _____

Father's / Guardian's Name_____

Address (if different from patient's) _____

_____

Cell Phone (___)_____ Home/Work Phone (___)_____

Email_____

Employer_____

Soc. Sec. #_____DOB_____

Do you have dental Insurance Coverage for the Minor/ Child? □Yes □ No

Plan Name_____ Phone (___)_____

Address_____

Group # _____ Policy _____

Mother's / Guardian' Name_____

Address (if different from patient's)_____

_____

Cell Phone (___)_____ Home/Work Phone (___)_____

Email _____

Employer_____

Soc. Sec # _____ DOB_____

Do you have Dental Insurance Coverage for the Minor/Child? □Yes □ No

Plan Name_____ Phone (___)_____

Address_____

Group # _____ Policy _____

Is your child eligible for treatment under Medical Assistance □ Yes □ No Child's Medical Assistance I.D. #_____

Date of Last visit to a dentist_____ For What Service?_____

Has child complained about dental problems? □ Yes □ No Is Fluoride taken in any form? □ Yes □ No

Does child brush teeth daily? □ Yes □ No Any injuries to mouth, teeth, head? □ Yes □ No
Does child use floss everyday? □ Yes □ No Any unhappy dental Experiences? □ Yes □ No
Any mouth habits- thumbsucking, nail biting, mouth breathing, pacifier, sleeping with bottle, etc? □ Yes □ No

CHILDS NAME_____

Minor/Child's Physician_____ City/ State_____ Phone (____)_____

Date of Last physical examination_____ Results_____

Is Minor/child under care of physician now? □ Yes □ No Medications_____

Receiving any medications or drugs? □ Yes □ No _____

Ever been hospitalized? □ Yes □ No _____

Ever had surgery? □ Yes □ No Allergies_____

Is there excessive bleeding when cut? □ Yes □ No _____

Has minor/child had any history of or difficulty with any of the following? If yes, please check.

□ A.I.D. S. / H.I.V □ Cerebral Palsy □ Epilepsy □ Kidney Disease □ Rheumatic Fever

□ Anemia □ Chicken Pox □ Fainting □ Liver Disease □ Sinus Problems

□ Asthma □ Latex Allergy □ Convulsions □ Hearing Problems □ Measles □ Thyroid Disease

□ Bladder Problems □ Diabetes □ Heart Problems □ Mononucleosis □ Tuberculosis

□ Cancer □ Drug/ Alcohol Abuse □ Hepatitis □ Mumps □ Special Needs Other: _____

In the Event of an emergency, whom should we contact?

Name_____ Relationship _____ Phone (___) _____

Name_____ Relationship _____ Phone (___) _____

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 herby 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 covered by insurance with _____
Name of Insurance Company (ies)
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 three years from the date signed below.

_____ _____
Signature of Parent, Guardian or Personal Representative Date

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

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In the event I cannot attend a dental appointment for _____
I, _____, give_____, my consent to fully act on my behalf. This includes all aspects of the dental appointment including signing of forms, receiving dental reports from Dr. Bain, discussion of patient history, consenting to recommended treatment, and full payment for services rendered.

My consent is also given for any decisions regarding medical emergencies that could possibly occur during my child's visit to the office.

Signed _____

Date _____

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Dear Parent,

We are excited to have your child as a patient at our office! We strive to offer the very best in pediatric dentistry so we can ensure your child has the right tools to maintain lifelong oral health and wellbeing. Below is a list of our office policies that are strictly enforced to ensure we extend the utmost courtesy to all of our busy parents. Thank you in advance for your consideration to our staff, patients, and other parents by following these policies.

● Each hygiene appt will consist of: a dental cleaning, exam, fluoride treatment (AAPD and ADA recommend every 6 months necessary for developing teeth), hygiene/diet instructions, and x-rays at 1 appointment per calendar year

● 2 business days for cancellations/reschedules. A $50.00 fee is applied for cancelled/rescheduled hygiene appointments, $100.00 for sedation/restorative appointments, and $250.00 for surgery appointments w/out prior notice. We may also require the patient to pre-pay for their out of pocket expense prior to rescheduling another appointment if cancellations have occurred more than once.
*10 Minutes late to an appointment is considered rescheduling without prior notice and a fee can be applied.

● A parent or legal guardian must accompany the child to the office and stay on premises for the duration of the appointment. We always welcome parents to come back with their child during the dental health visits. Should your child require dental treatment we allow only one parent to accompany the child and siblings will not be allowed into treatment areas. Children under the age of 13 are not allowed to be left in the waiting area unattended without someone, 18 years of age or older, accompanying them.

● We will file your primary insurance and can ESTIMATE what your insurance may cover. This is simply an estimate, not a guarantee of benefits. Any amount your insurance does not cover is the sole responsibility of the financially responsible party (parent or legal guardian) We will provide you with a superbill if you wish to file your secondary coverage from home.

● Payment must be made at time of service. NO EXCEPTIONS. After insurance pay a claim you have 30 days to pay any outstanding balance to avoid turning over the account to a collection agency.

● A $50.00 NSF fee will be charged on all returned checks. You will have 10 days to make payment in full by cash, credit card or money order.

_____ _____
(SIGNATURE OF PARENT/GUARDIAN) (DATE)

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I, _____, parent/guardian of

_____ consent to the use of their/his/her photographs and/or video footage by Dr. Anthony Bain's office on their website, Facebook page, and possible advertisements. The first name only of your child may be mentioned in such instances as our Cavity Free club on Facebook. Please speak with our front office if you have any questions or concerns.

I further understand that this consent may be withdrawn by me at anytime, upon written notice from me.

I give this consent voluntarily.

_____ _____

Signature Date

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CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION

Section A: Patient Giving Consent

Patient(s) Name: _____

Address:_____

Telephone:_____ E-mail:_____

Patient #:_____ Social Security #: _____

Section B: TO THE PATIENT – PLEASE READ THE FOLLOWING STATEMENTS CARE FULLY

Purpose of Consent: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities, and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy Practices before you decide whether to sign this consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses disclosures we may make of your protected health information, and of other important matters about your protected health information. A copy of our notice is available at request.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your health information that we maintain.

You may obtain a copy of our Notice of Privacy Practices, including any revisions of our notice at any time by contacting:

Contact Person: Dr. Anthony Bain
Telephone: 512-989-6900 Fax: 512-989-6901
Address: 619 S. Heatherwilde Blvd. Pflugerville, TX 78660

Right to Revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the contact person listed above. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation, and that we may decline to treat you or to continue treating you if you revoke consent.

SIGNATURE

I _____, have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that, by signing this consent form, I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

Signature: _____ Date: _____

If this Consent is signed by a personal representative on behalf of the patient, complete the following:

Personal Representative's Name:_____

Relationship to Patient: _____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT

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Patient Name: _____

Date: _____

It has been brought to our attention, that some companies have chosen insurance plans that provide coverage for fluoride treatments only once a year. Fluoride is a vital component of your child's bi-annual appointments. As a courtesy to our patients, we will file your insurance; however, please be aware that it is possible that the fluoride treatment may be denied. If this occurs, you will be billed $34.00 for this service. Thank you for allowing us to assist you in teaching your child the importance of dental health.

Today we will be providing the following services:

Comprehensive or Periodic Exam
Prophylaxis (Cleaning)
Fluoride Treatment
Bitewing X-rays (2 back teeth/top and bottom)
Periapical X-rays (2 front teeth/top and bottom)
Panoramic X-ray (6yrs. and Up)

Insurance coverage is only an estimation. Guarantor is responsible for treatments not covered by your insurance.

Parent/Guardian: _____