GET ACQUAINTED QUESTIONNAIRE

Date _____

Child's Name _____ ☐ M ☐ F Age _____ Date of Birth _____

Mailing Address _____ Social Security # _____

City _____ State. _____ Zip _____ Home Phone _____

Father/Guardian Name _____ Date of Birth _____ Social Security # _____

Driver's License # _____ Employer Name & Address _____

Business Phone _____ Present Position _____

Home/Cell Phone _____ Email Address: _____

Mother/Guardian Name _____ Date of Birth _____ Social Security # _____

Driver's License # _____ Employer Name & Address _____

Business Phone _____ Present Position _____

Home/Cell Phone _____ Email Address: _____

Who referred you? _____

Emergency Contact Name/Phone _____

Relationship _____

HEALTH HISTORY

A. DENTAL

Date of last visit to a dentist _____

Has your child complained about dental problems?	YES	NO
Have there been any unhappy dental experiences?	YES	NO
Any injuries to mouth-teeth-head?	YES	NO
Nurse/Bottle Habits/Sippy Cup	YES	NO
Does your child brush teeth daily?	YES	NO
Does your child let you help with tooth brushing?	YES	NO
Does your child let you assist with flossing?	YES	NO
Is fluoride taken in any other form than in toothpaste?	YES	NO

Child's attitude to dentist _____

Do you desire complete dental service for your child?	YES	NO
Has orthodontic treatment been recommended?	YES	NO

B. MEDICAL

Is your child in good health?	YES	NO

Comments _____

Does your child have regular medical exams?	YES	NO
Is your child taking any medication?	**YES**	**NO**

If so, what? And why? _____

Is your child allergic to latex?	YES	NO
Has your child ever experienced an unfavorable or allergic reaction to drugs including antibiotics (Penicillin) & local anesthetics or other drugs?	YES	NO

_____

Has child any history or difficulty with any of the following?

YES	NO	Abuse (physical/sexual)	YES	NO	Bladder Problems	YES	NO	Fetal Alcohol Syndrome	YES	NO	Mononucleosis (Mono)
YES	NO	ADHD/ADD	YES	NO	Bleeding Disorder	YES	NO	Frequent Exposure to	YES	NO	Pregnancy
YES	NO	Aids-HIV	YES	NO	Cancer			Tobacco Smoke	YES	NO	Rheumatic Fever
YES	NO	Anemia	YES	NO	Cerebral Palsy	YES	NO	Hearing Problems	YES	NO	Seizures
YES	NO	Asperger Syndrome	YES	NO	Chronic Chest Congestion	YES	NO	Heart	YES	NO	Sickle Cell
YES	NO	Asthma	YES	NO	Chronic Sinus	YES	NO	Hepatitis, Jaundice	YES	NO	Sleep Apnea
YES	NO	Autism	YES	NO	Convulsions	YES	NO	Kidney Problems	YES	NO	Speech Problems
YES	NO	Behavior Problems/	YES	NO	Depression	YES	NO	Leukemia	YES	NO	Thyroid Problems
		Developmental Problems	YES	NO	Diabetes or family history	YES	NO	Liver Problems	YES	NO	Tuberculosis (TB)
YES	NO	Bipolar	YES	NO	Down Syndrome	YES	NO	Mastoid Problems	Other: _____		
			YES	NO	Epilepsy	YES	NO	Meningitis	_____		

I understand the need for these questions to be answered truthfully. To the best of my knowledge, the answers I have given are accurate. I also understand it is very important to report any changes or updates in my child'd medical history.

Family Physician or Pediatrician _____ Phone # _____

Are other family members under our care? Name _____

Family history of general anesthesia problems, hospitalization _____

For Prompt filing of dental claims please fill out the following information completely if it applies.
Thank you for your help.

Dental Insurance Company _____ Policy Holder - Mr. or Mrs.
Policy Holder's S.S. # _____
Address where claims are to be sent _____ City _____ State _____
Group # _____ Subscriber or I.D. # _____
Is patient covered by another dental plan? _____ Name _____

FINANCIAL STATEMENT:

Normally, payment for dental treatment is expected when services are performed. We accept checks, cash, or credit card. If you have dental insurance, we will be happy to file any claims, however, you are still responsible for your account. Dental insurance coverage on your child rarely covers all expenses. Obligation for payment still belongs to you. You will receive a statement each month - accounts are due and payable monthly as work progresses, regardless of insurance coverage. Any overpayment on your account will be refunded to you when your child's dental work is completed.

Any account delinquent over 30 days will be turned over to a collection agency. There is a charge on all returned checks and any check not paid in cash on demand will be turned over to the district attorney for prosecution.

In order to make ideal dental care available to as many of our patients as possible, on more extensive cases we will submit a pre-determination of benefits to the insurance company.

OFFICE FIRST VISIT OR RECALL EXAM CONSENT:

A first or recall exam can include the following: 1.) oral examination, 2.) taking and reading dental x-rays that are indicated and can include, 2 bitewing X-rays, 2 periapical X-rays and or a Panorex, 3.) a dental cleaning with topical varnish fluoride, 4.) a consulation with the Pediatric Dentist. All X-rays are property of this office. I GIVE CONSENT FOR THE PROCEDURES.

_____ _____ _____

Signature of Parent/Guardian Relationship to Patient Date

BECAUSE YOUR CHILD IS A MINOR AND TO COMPLY WITH THE NEW LAW FROM THE STATE BOARD OF DENTAL EXAMINERS OF TEXAS, IT BECOMES NECESSARY THAT A SIGNED PERMISSION BE OBTAINED FROM A PARENT OR GUARDIAN BEFORE ANY DENTAL TREATMENT BE STARTED AND ACCOMPLISHED.

THIS SIGNED CONSENT FORM INDICATES THAT THE FOLLOWING HAS BEEN ACCOMPLISHED:

1. The parent or guardian has been explained the treatment plan and methods to be utilized.
2. The parent or guardian has been explained the drugs to be utilized for this treatment.
3. The parent or guardian has been given the different treatment options to include no treatment.
4. The parent or guardian has been explained the post-operative course and possibility of complications.
5. If your child requires conscious sedation, a separate consent form will be required for treatment.

The signature of a parent or guardian affixed below authorizes the completion of all agreed upon dental services, and the use of appropriate methods. This consent shall remain in full force and effect until cancelled by either party.

_____ _____ _____

Signature of Parent/Guardian Relationship to Patient Date

IF YOU RECEIVE ASSISTANCE FROM WELFARE / MEDICAID

YOU MUST HAVE A CURRENT MEDICAID CARD for a regular or emergency dental exam. It is also necessary for us to make a copy of your Medicaid card, please present it with this questionnaire and each time your child is seen by the dentist. If you do not bring your card each time, you are responsible for any charges when your child is treated. Please notify us if you become ineligible for these benefits.

CONSENT

I give this practice/clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for health care operations like quality reviews.

I have been informed that I may review the practice/clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice/clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice/clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

Signature: _____ Date: _____
Patient, Parent or Legal Guardian

I signed by patient represented, state relationship to patient_____

Dear Parents,

We welcome you to accompany your child during their exam and cleanings if you wish or you can choose to wait in the waiting area. This is at your discretion.

For treatment appointments, we kindly request that siblings not be observers as we would like to be completely focused on your child having treatment. If you would like to be at the bedside during treatment, please plan to bring an adult to care for your other children in the waiting area. For your children's safety, they must have adult supervision.

Due to HIPPA regulations regarding privacy; Video recordings, photos, and cell phone use is not permitted in the treatment area.

We apologize for any inconvenience this may pose; however, our focus is in your child's best interest.

Thank you for understanding and we appreciate your cooperation.

Respectfully,

Dr. Leticia Gutierrez Jeffords

Your signature below indicates that you have read and agree with this request.

Parent signature: _____

Printed name: _____

Date: _____

At the Gutierrez Pediatric Dentistry PC "Your Child's Dentist", we provide exceptional dental care and to help understand and manage your dental expenses.

Insured Patients: We participate with most PPO insurance plans in our service area, including **Medicaid**. If you are insured by a plan, we are contracted with but are unable to provide an up-to-date insurance card, payment in full is required for each visit until we can verify your insurance coverage. Understanding your insurance benefits **is your responsibility.** Please review your insurance company's guidelines for referrals, co-pays, and deductible amounts specifically for specialist visits. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payments & Deductibles: All co-payments and deductibles are to be paid at the time of service. This arrangement is part of your contract with your insurance company and reduces the administrative costs associated with providing you with dental care. As part of our contract with insurance companies, we must collect co-payments and deductibles from patients, and they cannot be waived by Gutierrez Pediatric Dentistry PC. Please help us keep administrative costs to a minimum by eliminating the need to send statements to you for payments due at the time of service. Patients with a high deductible plan who are unable to pay for services in full must provide partial payment (as estimated by our staff) and settle all remaining financial obligations by establishing a payment plan with our billing department. **All balances are due within 60 days or subject to additional collection efforts.**

Please be aware that some of the services you receive may be non-covered or not considered reasonable or necessary by insurers. Once your claim is processed, you may have a balance due for services rendered and **you are responsible for paying this amount. Non-covered Medicaid services will be discussed before treatment is provided.**

If your insurance changes, please notify us before your next visit so we can verify your plan coverage. If you have any other changes such as address, email, home phone, cell phone, etc., please call our office prior to your next scheduled appointment.

Self-pay & out-of-network patients: If you have no dental insurance, payment is due at the time service is rendered. If you are not covered by an insurance plan we are contracted with, payment in full is due at each visit.

If you have an outstanding balance and have not planned to pay your bill, no new appointments will be scheduled you will be sent to a collection agency SARMA. If you have a Dental Emergency, treatment will be provided to relieve pain and/or infection. Thank You for understanding our payment policy. Our practice is committed to providing the best treatment to our patients.

Sign: _____ **Date:** _____