RISING STARS PEDIATRIC DENTISTRY

PATIENT INFORMATION:

Name: _____ **Birth Date:** _____ **Age:** _____ Sex: □ F □ M
Address: _____ City: _____ State: _____ Zip: _____
Home Telephone # _____ Other # _____
Have we ***previously*** seen any siblings? No ( ) Yes ( ) If yes please list their names: _____
Whom may we thank for referring you to our office? _____

PARENT/GUARDIAN INFORMATION:

□ **Father** □ Stepfather □ Guardian □ Other _____
Name: _____ DOB: _____ SSN/ID: _____
Address (if different from child): _____
Place of Employment: _____ Work # _____
Home Telephone # _____ Cell # _____ Email: _____

□ **Mother** □ Stepmother □ Guardian □ Other _____
Name: _____ DOB: _____ SSN/ID: _____
Address (if different from child): _____
Place of Employment: _____ Work # _____
Home Telephone # _____ Cell # _____ Email: _____

INSURANCE

As a courtesy we will accept assignment of benefits from most insurance companies. In order to do so you must provide us with a copy of your insurance card and the following information:
Do you have dental insurance/Medicaid? □ Yes □ No Do you have more than one dental insurance? □ Yes □ No
Name of the person insured: _____ Relationship to the patient: _____
Place of Employment: _____Member ID#_____
Insurance Company: _____Telephone # _____ Group # _____
Claims Mailing Address: _____

DENTAL HISTORY

Why is your child here today? _____
Is this your child's first visit to the dentist? □ Yes □ No If no, date of the last visit: _____
Please describe how you think your child will behave today. Check all that apply:
□ Friendly □ Happy □ Timid □ Afraid □ Resistant
Does your child receive fluoride in any form? □ Yes □ No Please describe: _____
Has your child inherited any dental characteristics? _____
Have there been any injuries to your child's teeth? _____

Place a check in the circle below if your child has or has had any of the following problems:

□ Cavities	□ Toothache	□ Bad breath
□ Crooked teeth	□ Sensitive to sweets	□ Bleeding gums
□ Sensitive to hot/cold	□ Frequent headaches	□ Discolored teeth
□ Loose teeth	□ Teeth bumped	□ TMJ popping/clicking
		□ Jaw pain from joint

Does your child have any of the following oral habits?

□ Thumb sucking	□ Lip biting	□ Teeth Grinding
□ Pacifier Use	□ Other_____	_____

How often does your child brush his/her teeth? _____ Electric toothbrush YES / NO

How often does your child floss his/her teeth? DAILY / SOMETIMES / NEVER

At what age did your child stop using the: □ Bottle? _____ Sippy cup? _____

MEDICAL HISTORY

Child's Physician_____
Address _____ Phone # _____
Is your child in good general health? □ Yes □ No
If no, please describe _____
Does your child have any physical disabilities/developmental delays? □ Yes □ No
If yes, please describe _____
Are your child's immunizations and booster shots up to date? □ Yes □ No
Has your child had any surgical operations? □ Yes □ No
If yes, for what? _____
Has your child ever been hospitalized? □ Yes □ No
If yes, for what? _____

Has your child had or does he/she now have:

- Latex Allergies **YES or NO** Seasonal Allergies **YES or NO**
- Food Allergies_____
- Drug Allergies _____

1. Has your child had any history of asthma or breathing problems? _____
   - Has your child been to the ER for an asthma attack? _____
   - What induces the breathing problems? _____
   - What asthma medication does your child take? _____

PLEASE CIRCLE YES/NO TO ALL CONDITIONS LISTED BELOW

3.	Autism Spectrum	Yes No	14.	Hearing/Vision Impairment	Yes No	25.	Steroids therapy or chemotherapy	Yes No
4.	Sensory Integration Issues	Yes No	15.	Eating disorders	Yes No	26.	Nervous or emotional disorders	Yes No
5.	ADD/ADHD	Yes No	16.	Abnormal Bleeding or bruising	Yes No	27.	Convulsions or seizures	Yes No
6.	Heart Trouble or heart murmur	Yes No	17.	Prolonged Bleeding /Transfusions	Yes No	28.	Date of last seizure _____	
7.	Rheumatic heart disease or fever	Yes No	18.	Birth Defects	Yes No	29.	Frequent diarrhea or vomiting	Yes No
8.	Blood diseases or anemia	Yes No	19.	Kidney Disease	Yes No	30.	Mumps, measles, or chickenpox	Yes No
9.	AIDS virus	Yes No	20.	Cleft lip or palate	Yes No	31.	Cancer, tumors, growths or cysts	Yes No
10.	Herpes virus or shingles	Yes No	21.	Scarlet fever or high fever	Yes No	32.	Sinus problems or drainage	Yes No
11.	Diabetes	Yes No	22.	High or low blood pressure	Yes No	33.	Tuberculosis or TB exposure	Yes No
12.	Ear, eye, nose or throat trouble	Yes No	23.	Liver disease	Yes No	34.	Problems with Anesthesia	Yes No
13.	Stomach ulcers	Yes No	24.	Jaundice or hepatitis	Yes No	35.	Thyroid disease	Yes No

CURRENT MEDICATIONS:

Name/Strength (mg)	**How often?**	**Reason taken**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SOCIAL HISTORY:

Does your child have problems with any of the following? □ Speech □ Hearing □ Vision □ Sleep
Do you consider your child to be? □ Advanced in learning □ Progressing normally □ A slow learner
Child's first language? _____ Second or other languages? _____
Is your child adopted? □ Yes □ No If yes, at what age? _____
How does your child tolerate dental/medical care? _____
Child's favorites (pet, toy, color, friend, hobby etc.) _____

Authorization and Release:

I understand that payment of a calculated % is due at the time treatment is rendered, and that my dental insurance carrier may pay less then the actual bill for service. I agree to be responsible for payment of all services rendered on behalf of my dependant(s), including any balance not paid by the dental insurance company within 30 days of the date of service. I understand that I am responsible for handling any disputes regarding amount of payment with the insurance company. I authorize and request my insurance company to pay directly to the dentist or dental group any insurance benefits otherwise payable to me.

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 child's health. It is my responsibility to inform the dental office of any changes in my child's medical status. I authorize the dentist to release any information, including the diagnosis and records of any treatment or examination rendered to my child during period of such dental care to third party payers' and/or health practitioners.

Signature of Parent/Guardian: _____

Printed Name: _____ Date: _____

PEDIATRIC DENTISTRY CONSENT for DENTAL PROCEDURES and ACKNOWLEDGEMENT for RECEIPT of INFORMATION

It is the policy of this dental practice to inform parents of all procedures contemplated for your child. At each examination appointment we will identify any dental treatment needed and describe this to you and your child. Each regular examination visit consists of oral hygiene instructions, cleaning of the teeth, topical application or fluoride, radiographs (x-rays) if needed, and examination of the teeth, hard and soft tissues of the mouth and the bite. Any other treatment needed such as fillings, caps, Extractions, etc. will be performed at a separate appointment after obtaining your permission.

State Law requires that we obtain your written informed consent for any treatment given your child as a legal minor.

Please read this form carefully and ask about anything that you do not understand. We will be pleased to explain further.

1. I hereby authorize and direct Dr. Michelle L. Freeze / Dr .Shiny R. Thomas / Dr. Jeffrey Gregerson assisted
2. by other dentists and/or dental auxiliaries of her choice, to perform upon my child the following dental treatment or oral surgery procedures, including the use of any necessary or advisable local anesthesia, radiographs (x-rays) or diagnostic aids.

2. In general terms the dental procedures or operations will include:
   - A. Cleaning of the teeth and the application of topical fluoride.
   - B. Application of plastic "sealants" to the grooves of the teeth.
   - C. Treatment of diseased or injured teeth with dental restoration (fillings or caps).
   - D. Replacement of missing teeth with dental prosthesis.
   - E. Removal (extraction) of one or more teeth.
   - F. Treatment of malposed (crooked) teeth and/or oral development or growth abnormalities.
   - G. Use of local anesthesia, by injection, to numb the teeth worked on. Numbness usually lasts from 1½ -3 hours. Allergic reactions are rare. Your child will be cautioned not to bite the numb lip and cheek. Please do not tell your child that they are going to get a "Shot". We have our special way to inform them of this.
   - H. Use of behavior management techniques outlined on page 4.

I fully understand there is a possibility of surgical and/or medical complications developing during or after the procedure. These risks and side effects may include adverse reaction to a drug that may cause necessary hospitalization, further surgical procedures, disability, system impairment, permanent or temporary nerve damage, brain damage or death. I further authorize Dr. Michelle L. Freeze/ Dr. Shiny R. Thomas/ Dr. Jeffrey Gregerson to perform treatment as may be advisable to preserve the health and life of my child.

I hearby state that I have read and understand this consent and the behavior management techniques on page 4 (if applicable) and that all questions about the procedure or procedures have been answered in a satisfactory manner; and I understand that I have a right to be provided with answers to questions which may arise during the course of my child's treatment.

I further understand that this consent will remain in effect until such time that I chose to terminate it.

Date: _____ Time: _____ am / pm

Patient's Name: _____

Signature of Parent of Guardian: _____

Relationship to Patient: _____ Witness Signature: _____

BEHAVIOR MANAGEMENT TECHNIQUES

It is our intent that all professional care delivered in our dental operatories shall be the best possible quality we can provide for each child. Providing a high quality of care can sometimes be made very difficult, or even impossible, because of the lack of cooperation of some child patients. Among the behaviors that can interfere with the proper provision of quality dental care are: hyperactivity and resistive movements. Refusing to open the mouth or keep it open long enough to perform the necessary dental treatment, and even aggressive or physical resistance to treatment, such as kicking, screaming and grabbing the dentist's hands or the sharp dental instruments.

All efforts will be made to obtain the cooperation of the child dental patients by the use of warmth, friendliness, persuasion, humor, charm, gentleness, kindness, and understanding.

There are several behavior management techniques that are used by pediatric dentists to gain the cooperation of child patients to eliminate disruptive behavior or prevent patients from causing injury to themselves due to uncontrollable movements. The more frequently used pediatric dentistry behavior management techniques are as follows:

1. Tell-show-do: The dentist or assistant explains to the child what is to be done using simple terminology and repetition and then shows the child what is to be done by demonstrating with instruments on a model or the child's or dentist's finger. Then the procedure is performed in the child's mouth as described. Praise is used to reinforce cooperative behavior.

2. Positive reinforcement. This technique rewards the child who displays any behavior which is desirable. Rewards include compliments, praise, a pat on the back, a hug or a prize.

3. Voice Control: The attention of a disruptive child is gained by changing the tone or increasing the volume of the dentist's voice. Content of the conversation is less important than the abrupt or sudden nature of the command.

4. Mouth props: A rubber or plastic device is placed in the child's mouth to prevent closing when a child refuses or has difficulty maintaining an open mouth.

5. Sedation: Sometimes drugs are used to relax a child who does not respond to other behavior management techniques or who is unable to comprehend or cooperate for the dental procedures. These drugs may be administered orally. The child does not become unconscious. Your child will not be sedated without you being further informed and obtaining your specific consent for such procedure.

6. General anesthesia: The dentist performs the dental treatment with the child anesthetized in the hospital operating room. Your child will not be given general anesthesia without your being further informed and obtaining your specific consent for such procedure.

Initials: _____ Date: _____

RISING STARS PEDIATRIC DENTISTRY

FINANCIAL POLICY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions, please discuss them with our billing staff or office manager. We are dedicated to providing the best possible care and service to your child and regard your complete understanding of our financial policies as an essential element of care and treatment.

- Payment is due at the time of service unless other arrangements have been made in advance by either yourself or your dental plan coverage. For your convenience, we will accept cash, check, visa, master card, discover and American Express.

- Your insurance is a contract between you and your insurance company. As a courtesy, after your first initial visit and upon verification of coverage, we will file your insurance claim for you if you assign the benefits to the doctor; in other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will look to you for payment. If we later receive a check from your insurer, we will refund any overpayment to you.

- We are contracted with Delta Dental (Premier only), Ameritas, Principal, Humana, United Concordia (Military & National Fee for Service Plan), MetLife and some Connection Dental plans. If you are covered by one of these plans, we will bill your plan and will only require you to pay your estimated co-payment at the time of service. Any remaining balance would be due upon receipt of our statement.

- All dental plans are not the same and do not cover the same services. In the event your dental plan determines a service to be "not covered" or over what they deem "usual and customary charges"' you will be responsible for this amount. Payment is due upon receipt of statement from our office. If payment is not made upon receipt of our statement, we will no longer file your insurance. Therefore we will expect payment in full at the time of service. We do honor some Discount Dental plans so please ask our front office staff to see if we accept your plan.

- Your estimated portion of our fees for scheduled hospital procedures is due when scheduling the surgery date. Any balance remaining after your dental plan pays is your responsibility and payment is due upon receipt of statement from our office.

- The **adult accompanying** the child is responsible for payment for services rendered to a child patient.

- **Missed/Late Appointment(s) Policy – Although, we make every attempt to remind you of your scheduled appointment, it is your responsibility to remember all appointment date(s)/time(s). The doctors have reserved this time, especially for you and your child to meet their dental needs. Cancellations require a 24 hour prior notice, or your account may be assessed a $25 missed appointment fee. Late arrivals (more than 15 minutes) may require rescheduling your child to another day. Please be on time so the doctor can provide the best treatment for your child. _____(Initial) I have read and understand.**

I have read and understand the financial policy of the practice, and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

_____ _____

PRINTED PATIENT NAME **DATE**

_____ _____

SIGNATURE OF RESPONSIBLE PARTY **DATE**

RISING STARS PEDIATRIC DENTISTRY

Michelle L. Freeze D.M.D.
Shiny R. Thomas D.D.S.
Jeffrey B. Gregerson D.M.D

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

I authorize Dr. Michelle Freeze/Dr. Shiny Thomas/Dr. Jeffrey Gregerson to release to hospital or health care service plans, insurance companies, self-insurers, or their representatives, any and all information and records (including x-rays) about my medical history, or about services rendered or treatment given to my child/children that is needed to review, investigate or evaluate any claim for benefits.

If my coverage is under a group master agreement held by my employer, an association, trust fund, union or a similar entity, this authorization also permits disclosure to them for purposes of utilization review or financial audit.

AUTHORIZATION FOR SUBMISSION OF CLAIMS AND ASSIGNMENT OF BENEFITS

I authorize Dr. Michelle Freeze/Dr. Shiny Thomas/Dr. Jeffrey Gregerson to submit claims for payment for services to healthcare service plans or insurance companies named below, on my behalf and in my name, and assign to Dr. Freeze/Dr. Thomas/Dr. Gregerson the groups insurance benefits otherwise payable to me, but not to exceed the provider's actual charges for covered services.

NAME OF INSURANCE COMPANY/COMPANIES

1. _____(Primary)
2. _____(Secondary)

This authorization shall remain effective for up to five years from this date. I know I have a right to receive a copy of this authorization if requested.

I also understand that although Dr. Freeze/Dr. Thomas/Dr. Gregerson strives to give the most accurate insurance information possible with regards to my plan, it is ultimately my responsibility as the insured/subscriber to know and understand my benefits, limitations and exclusions of my individual policy.

(NOTE: WE ARE FILING YOUR INSURANCE AS A COURTESY. FOR US TO CONTINUE THIS SERVICE, WE ASK THAT ANY BALANCE NOT PAID BY YOUR INSURANCE COMPANY BE PAID BY YOU AT THE TIME YOU RECEIVE OUR STATEMENT.)

_____ _____
SIGNATURE DATE

RISING STARS PEDIATRIC DENTISTRY

Michelle L. Freeze D.M.D.
Shiny R. Thomas D.D.S.
Jeffrey B. Gregerson D.M.D

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
- ☐ Communications barriers prohibited obtaining the acknowledgment
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (Please Specify)

_____
_____
_____

RISING STARS PEDIATRIC DENTISTRY

Michelle L. Freeze D.M.D.
Shiny R. Thomas D.D.S.
Jeffrey B. Gregerson D.M.D

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, 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 for 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) a 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 healthcare. 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.

Marking Health-Related Services: We will not use your health 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 authorize 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).

PATIENTS RIGHTS

Access: You have the right to look at or get copies of your health information, with limited exceptions. (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. You may be charged reasonable copy fee as defined by the Texas Dental Authority. You may also request access by sending us a letter to the address at the end of this Notice. If you request copies to be sent through the mail, you will be charged for packaging and postage. 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 if 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 you 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 your access to your health information or in response to a request 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 to the U.S. Department of Health and Human Services. We will provide you with the address to file your 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 the U.S. Department of Health and Human Services.

Contact Officer: Nancy Abrams

Telephone: 512-266-7200 Fax: 512-583-0675

E-mail: Nancy@SmileLikeAStar.com

Address: 14005 N Hwy 183 Suite 800 Austin, TX 78717

This Form is educational only, does not constitute legal advice, and covers only federal, not state, law (August 14, 2002).