S.M. HAIDER, D.D.S., P.A.
Pediatric Dentistry • Facial Orthopedics • Orthodontics

PATIENT ACQUAINTANCE INFORMATION

Child's Name______________________ Age________ Date of Birth____________

Prefers to be called______________________ Sex________ Weight____________

I. CHILD'S MEDICAL HISTORY

	Yes	No
1. Does child have a health problem?	❑	❑
2. Is child under care of physician now?	❑	❑
3. Is there any history or excessive bleeding in child or family?	❑	❑
4. Has child ever had any emotional, mental, or nervous problem?	❑	❑
5. Has child experienced any unfavorable reactions to any drugs?	❑	❑

6. Regular medications being taken by child______________________
7. Medicines or drugs to which child is allergic______________________
8. Any other allergies______________________
9. Previous hospitalizations______________________
10. Has child had any history or difficulty with the following? If so, please check ( ).

❑ Heart	❑ Anemia	❑ Chicken Pox	❑ Cleft lip or Palate
❑ Lungs	❑ Asthma	❑ Bleeding Disorders	❑ Cerebral Palsy
❑ Liver	❑ Fainting	❑ Epilepsy	❑ Rheumatic Fever
❑ Kidney	❑ Diabetes	❑ Convulsions	❑ Speech Problems
❑ Hepatitis	❑ Mumps	❑ Tuberculosis	❑ Chronic Sinusitis
❑ Hearing	❑ Measles	❑ Malignancy	❑ Heart Murmur
❑ Handicap/Disabilities	❑ HIV+/AIDS	❑ Rheumatic Fever	❑ Allergies to Latex

DOCTORS NOTES:

II. CHILD'S DENTAL HISTORY

	YES	NO
1. Has child ever had a local anesthetic?	❑	❑
2. Has child had any unfavorable dental experiences?	❑	❑
3. Had child had any injuries to the mouth or teeth?	❑	❑
4. Does child have a toothache now?	❑	❑
5. Has child recently had a toothache?	❑	❑
6. Does child have any mouth habits? (thumbsucking, nailbiting, mouthbreathing)	❑	❑
7. Does child have TMJ problems?	❑	❑
8. Does child have a bite problem?	❑	❑

9. Last dental examination______________________
10. Last dental X-rays______________________
11. Last topical fluoride treatment______________________
12. Reason for this visit______________________

Please identify any dental or medical problem of special concern or provide any other information which you think might be important in the care of your child.______________________

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★★(OVER)★★

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III. GENERAL INFORMATION

1. Child's Name____________________
2. Parent's Names:
   Father____________________ Mother____________________
3. Home Address____________________ Home Phone____________________
   City____________________ State__________ Zip____________________
   E-mail____________________ Cell Phone____________________
4. Occupation and place of employment
   Father____________________ Bus Phone____________________
   Mother____________________ Bus Phone____________________
5. Parent or guardian responsible for this account
   Name____________________
6. Dental Insurance Carrier (if applicable)____________________
   Policy No.____________________ S.S. #____________________
7. What other children in your family have we seen?____________________
8. Parent's Dentist____________________
9. Child's Pediatrician (physician)____________________
10. Who referred your child to our office?____________________

IV. CONSENT FOR TREATMENT OF A MINOR:

The undersigned hereby authorizes Dr. Haider to perform the examination including x-rays and, after explanation, all forms of treatment, medication, and therapy indicated for the dental care of the above named child. This consent shall remain in full force and effect until cancelled by either party.

Signed____________________

Relationship____________________ Date____________________

All fees for services rendered are payable at the conclusion of each appointment unless other financial arrangement have been made. All account in excess of five weeks past due are subject to a late charge.

INSURANCE CLAIM POLICY

As a courtesy to our patients, we will be happy to file your insurance for you. In order for us to give you the most efficient service possible, you will need to provide our office with all of your current insurance information. In the event that you do not have all of the below information with you, please feel free to use our courtesy phone in the check out area. Unfortunately, due to the high volume of patients whom have insurance coverage, we must rely on the parents/ guardians to provide this for us. Please fill out the below information, and provides us with your insurance card so that we may make a copy of it for the patient's files.

Patient(s) Name(s):____

Employee Name:____

Employee Birth dates:____

Employee Social Security:____

Employer:____

Insurance:____

Insurance Address:____

____

Insurance Group #____

Insurance Phone #____

- ***You will be expected to pay your deductible and estimated insurance % the day of services are rendered, unless other arrangements have been made in advance. Since we file only as a courtesy for our patients, our billing service will send you a statement every month updating you on any insurance payments that have been made toward your account. After 90 days, the balance on the account becomes your (the parents) responsibility, regardless of any pending situations with your insurance. However, if you should ever need our office to re file a claim or assist you with insurance problems, please give us a call.***

I have read and understand the above insurance policy.

Sign XX:____ **Date:**_______________

Kidz & Teen Dental

Syed M. Haider D.D.S., P.A.
4100 Fairway Court, Bldg #5, Ste 520,
Carrollton, TX 75010
972-939-KIDZ (5439)

Cancellation Policy

We reserve time in our schedule especially for you and your child, and in consideration of others we request at least 24 hours notice prior to cancellation of appointments. We do understand that there are circumstances that may prevent you from keeping your child's appointment, however with providing us as much notice as possible we may be able to contact another family who would like that appointment time. Afternoon appointments fill quickly, and canceling with less then 24 hours notice does not allow us enough time to schedule another patient in need of treatment, therefore a **cancellation** or **no-show** fee of $25.00 may apply if your child is unable to make their appointment. Patients that are running late area asked to call as soon as possible to check with the staff if they will still be able to keep their appointment. Also, cancellations are not accepted if left on the answering service and the appointment will not be considered cancelled unless you call during regular business hours and speak with one of our scheduling coordinators.

Patients who have appointments for restorative treatment may have their appointments rescheduled if they are more than 15 minutes late for their appointment time in consideration for other patients.

Appointments cancelled with less than 24 hours notice on a school holiday or an after school time will not be rescheduled on another school holiday or after school appointment time, as they are most popular appointments.

We greatly appreciate your cooperation in helping us providing you with excellent care for your family. Please sign below that you have read, and acknowledge the above information provided to you. You may also have a copy for your records at your request.

Parent/ Guardian: ______________________________

Date: ______________________________