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._____

_____

_____

★★(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.

Kidz & Teen Dental

4100 Fairway Court, Ste: 520, Carrollton, TX 75010

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 appointment. This will allow our office to accommodate another person in need of attention. 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 than 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 $50.00 will be applied if your child is unable to make to their Recare appointment and no-show fee of $100 to their surgery appointment.** Patients that are running late are 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 machine and the appointment will not be considered canceled 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 canceled with less than 24 hours' notice on a Saturday's, school holiday's or an after school time will not be rescheduled on another Saturday, 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: _____

Please sign here

KIDZ & TEEN DENTAL

4100 FAIRWAY CT, STE # 520
CARROLLTON, TX 75010-6505
PH:(972)939-KIDZ(5439)
FAX: 972-939-7022

CONSENT FOR USE AND DISCLOSURE IF HEALTH INFORMATION

Name:_____ Date of Birth:_____
Address:_____
Telephone:_____Social security #:_____

To the patient: *PLEASE READ THE FOLLOWING STATEMENT CAREFULLY*

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 the consent. Our notice provides a description of our treatment, payment activities and healthcare operations, of the uses and disclosures. We may make a copy of your protected health information and not of other important matters about your protected healthcare information. A copy of our notice accompanies this consent. We encourage you to read it carefully and completely before signing this consent.

We deserve the right to change our privacy practices as described in our Notice of Privacy Practice. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain changes. Those changes may apply to any of your protected 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.

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 the 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 if you revoke this consent.

I _____had full apportunity to read and consider the contents of this
(Please Print name)
consent form. I have reviewed the 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 patient, complete the following.

Personal Representative's name:_____

Relationship to patient:_____

YOU ARE ENTITLED TO A COPY OF THIS CONSENT AFTER YOU SIGN IT
Include completed consent in the patient's chart.

Kidz & Teen Dental

Syed M. Haider, D.D.S. PA **4100 Fairway Ct, Suite # 520,**

972-939-KIDZ (5439) **Carrollton, TX 75010.**

Patient Name: _____ Patient Date of Birth: _____

As a courtesy to our patients, we will be happy to file a claim to your insurance for you. In order for us to give you the most efficient service possible, you will need to provide our office with your current dental insurance information prior to your dental visit. You will be expected to pay your deductible and estimated insurance percentage the day services are rendered. Please select one or all options below that apply to you.

_____ **SELF PAY**: Initial here to attest that there is no active dental insurance coverage for this patient. (This option waives the right to file a claim with any insurance carrier including Medicaid and CHIP)

_____ **DENTAL INSURANCE SINGLE COVERAGE**: Initial here if the patient has coverage with only one dental insurance company. Your insurance policy contract requires you to choose this option only if there is no additional coverage available.

_____ **DENTAL INSURANCE DOUBLE COVERAGE**: Initial here if the patient has coverage with more than one company including Medicaid and CHIP. Your insurance policy contract requires you to provide all policy information regardless of the benefits. You do not have the right to choose one policy over the other.

PRIMARY INSURANCE INFORMATION:

Insurance Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Name of Employer: _____

ID or Social Security #: _____ Group #: _____

SECONDARY INSURANCE INFORMATION:

Insurance Name: _____ Policy Holder Name: _____

Policy Holder Date of Birth: _____ Name of Employer: _____

ID or Social Security #: _____ Group #: _____

It is my responsibility to accurately inform the office of any insurance coverage prior to my visit. This is to include any changes in existing coverage's. I understand that I will be responsible for any charges resulting from my failure to provide the office with the correct information. I will be required to present proper insurance identification including any secondary coverage prior to my visit. By signing below, I confirm that the above information is true and accurate.

_____ _____ _____

PRINT NAME (Patient, Parent, Guardian) SIGNATURE DATE