MAVERICK SMILES

PEDIATRIC DENTISTRY

SMILE BIG. STAND OUT. BE YOU.

New Patient Information

Welcome to Maverick Smiles! Thank you for filling out this form completely.

Today's Date _____ How did you find out about our office? _____

Patient's Name _____
Last First Middle

Patient's Date of Birth _____ Sex ❑ Male ❑ Female

Social Security Number_____ Preferred Name _____

Patient's Home Address _____

City _____State _____ Zip _____ Phone # _____

School _____ Grade _____

Names and ages of siblings in family _____

Do parents live together? ❑ Yes ❑ No If not, with whom does the child reside? _____

Parent or Guardian Information ❑ Mother ❑ Father ❑ Guardian

Name _____ DOB _____ Occupation _____

Employer _____ Work Phone # _____

SS# _____ Home # _____ Cell # _____

Marital Status _____ E-Mail address _____

Parent or Guardian Information ❑ Mother ❑ Father ❑ Guardian

Name _____ DOB _____ Occupation _____

Employer _____ Work Phone # _____

SS# _____ Home # _____ Cell # _____

Marital Status _____ E-Mail address _____

Person responsible for payment of account _____ Driver's license #_____

Please list any other relatives/guardians (include relationship to patient) that are authorized to receive information about this patient: _____

_____

Dental Insurance

Subscriber's Name_____ Relationship _____Date of Birth _____

SS# _____ Employer_____

Insurance Company Name/Address_____

Group # _____ Member ID # _____

Insurance Company Phone # _____

_____ _____

Signature of Legal Consent Date

MAVERICK SMILES

PEDIATRIC DENTISTRY

SMILE BIG. STAND OUT. BE YOU.

Medical and Dental History

Patient's Name _____ Age_____ Date of birth_____ ❑ Male ❑ Female

MEDICAL HISTORY

Yes	No	
❑	❑	Is patient in good health?
❑	❑	Is patient under the care of a pediatrician? Reason:_____ Physician's name and contact phone number _____
❑	❑	Does patient have any history of major illness? Please explain? _____
❑	❑	Has patient ever been hospitalized? Reason?_____
❑	❑	Is the patient receiving any medication/drugs presently? Please give medications and reason. _____
❑	❑	Does patient have any allergies or drug sensitivity? Please list. _____
❑	❑	Does patient have a tendency toward: ❑ colds ❑ sore throat ❑ ear infections ❑ sinus congestion ❑ breathing problems?
❑	❑	Have tonsils and/or adenoids been removed? What age? _____
❑	❑	Is your child under the care of a specialist? Reason _____ Contact Information _____

Check any of the following conditions for which the patient has been treated:

❑ ADD/ ADHD	❑ Emotional Problems	❑ Nutritional Problems
❑ Autism	❑ Endocrine Problem	❑ Prolonged Bleeding
❑ Blood Disorders	❑ Fainting/Dizziness	❑ Rheumatic Fever
❑ Bruise Easily	❑ Heart Problems	❑ Sickle Cell Anemia
❑ Cerebral Palsy	❑ Hepatitis	❑ Speech/Hearing Problem
❑ Diabetes	❑ HIV/AIDS	❑ Tuberculosis

Any other important medical, psychological, or disability problems? Yes ❑ No ❑ Please describe below.

_____

_____

DENTAL HISTORY

Previous Dentist_____

Yes	No	
❑	❑	Have there been any injuries to the face, mouth or teeth? _____
❑	❑	Has the patient ever sucked his/her thumb or fingers? Until what age? _____
❑	❑	Does the patient have any speech problems?_____
❑	❑	Is the patient a "mouth breather"? While awake?_____
❑	❑	Does the patient have noticeable problems in chewing or swallowing? _____
❑	❑	Any clicking, popping, or discomfort upon opening or closing their mouth? _____
❑	❑	Does the patient see a dentist regularly? Date the patient was last seen?_____
❑	❑	Has any previous dental treatment occurred? If yes, what? _____
❑	❑	Were there any problems with the previous dental treatment? If yes, what were they? _____
❑	❑	Is your drinking water fluoridated?
❑	❑	Are supplemental fluorides (e.g. rinse, gel, tabs) used? Please describe. _____

How often are teeth brushed? _____ Flossed? _____ By whom?_____

If there are any special concerns, please state in your own words. _____

How do you expect your child to react to his/her visit today? ❑ excellent ❑ good ❑ fair ❑ poor ❑ not sure

To the best of my knowledge, the questions on this form have been answered accurately. I understand that providing incorrect information can be dangerous to the patient's health. It is my responsibility to inform the dental office of any changes in the patient's medical status. I authorize the dental staff to perform any necessary dental services the patient may need. I also authorize the dentist to release any information including diagnosis and the records of treatment or examination rendered to the patient during the period of such care to third-party payers and/or health practitioners. I authorize the use of radiographs and photographs for the purpose of teaching and scientific publications. I request that my insurance company pay directly to Maverick Smiles Pediatric Dentistry, LLC. I understand that my insurance provider may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered to the patient. I also authorize a comprehensive examination including necessary radiographs and other indicated diagnostic procedures needed to accomplish these services.

_____ _____

Signature of Legal Consent Date

MAVERICK SMILES

PEDIATRIC DENTISTRY

SMILE BIG. STAND OUT. BE YOU.

HIPPA PATIENT CONSENT FORM

I understand that I have certain rights to privacy regarding my protected health information. These rights are given to me under the Health Insurance Portability and Accountability Act of 1996 (HIPPA). I understand by signing this consent I authorize you to use and disclose my protected healthy information carry out:

- Treatment (Including direct or indirect treatment by other healthcare providers involved in my treatment)
- Obtaining payment from third party payers (e.g. my insurance company)
- The day-to-day healthcare operations of your practice

I have also been informed of and given the right to review and secure a copy of your Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPPA. I understand that you reserve the right to change the terms of this notice from time to time and that I may contact you at any time to obtain the most current copy of this notice.

I understand that I have the right to request restrictions on how my protected health information is used and disclosed to carry out treatment, payment and health care operations, but that you are not required to agree to these requested restrictions, However, if you do agree, you are then bound to comply with this restriction. I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Date _____

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

MAVERICK SMILES

PEDIATRIC DENTISTRY

SMILE BIG. STAND OUT. BE YOU.

Welcome to our office. Here at Maverick Smiles Pediatric Dentistry, we have one simple goal and that is to provide exceptional dental health care in a safe, clean and fun environment. In order to partner with you and your family, we have put together some office guidelines to ensure your experience goes smoothly.

Appointment Guidelines:

- Appointment times are reserved specifically for your child. If you are more than 15 minutes late for your reserved time, the appointment may need to be rescheduled to another day.
- If you are unable to make your appointment or unable to give 24 hours' notice for an appointment cancellation, there will be a $25.00 charge that must be paid prior to making any further appointments.

Payment Guidelines:

- The parent or guardian accompanying the patient is responsible for payment. For unaccompanied minors, non-emergency treatment will be denied unless charges have been preauthorized.
- Fees for dental services are due at the time of treatment. Our office will file with all insurance companies for treatment provided. If we are not in network with your insurance, we will still file, but you will be responsible for any out-of-network costs. Any remaining balance that exceeds 30 days from the date of service will become your responsibility. Treatment plans and financial options will be presented prior to services being rendered.
- A finance charge of 1.5% will be applied monthly if an account balance has not been paid within 90 days. After 120 days, if balance is still unpaid, the account will be turned over to collections.

Insurance Guidelines: Maverick Smiles Pediatric Dentistry will file with all dental plans with the following terms-

- You must provide current and accurate dental insurance information when appointment is scheduled.
- A general breakdown of your individual dental benefits will be obtained by Maverick Smiles prior to your initial visit. You will be responsible for any estimated portion that is not covered by your insurance plan. This amount will be due at the time services are rendered. Once insurance payment is made, you will be informed of any remaining balance or credit.
- 100% of the fee will be due at the time of service for all services not covered under insurance.

If there are any questions or concerns about these guidelines, please feel free to discuss those with us!

_____ _____

Signature of Legal Consent Date

MAVERICK SMILES

PEDIATRIC DENTISTRY

SMILE BIG. STAND OUT. BE YOU.

Patient Photo Release Form

_____

Patient Name

I hereby authorize Maverick Smiles Pediatric Dentistry to take photographic, slide, and video images of my teeth, jaws, and face. I understand that the images will be used as a record of my care and may be used for communication with other health care professionals, educational publications (dental journals), and educational lectures. These images may also be used for advertising purposes (including website publication, Facebook post, etc.).

I further understand that if these images are used in any publication or as part of a demonstration, my identifying information (first name only) could be used unless stated differently below. I do not expect compensation, financial or otherwise, for the use of these images. If I wish to revoke this consent, I may do so in writing.

If declining to the release of photos in accordance with the terms above, please initial the option below:

_____ I do not agree to the use of photographs in any of the above stated situations.

If consenting to the release of photos in accordance with the terms above, please initial the option below:

_____ I agree to the use of photographs in any of the above stated situations.

_____ _____

Patient Name Date

_____

Legal Guardian Signature