Welcome to our Practice!

Please take a moment to fill out this form so we can get to know you better.

Guardian Name ________________________________ Guardian DOB ___________________________

Patients Name ____________________________ Male / Female

DOB ______________________ Age __________ School _______________________________________

MAILING ADDRESS

Street ____ APT _________________

City _______________________________________ State ________________ Zip _________________

1 Phone ___________________ 2 Phone ___________________ Email __________________________

METHOD OF APPOINTMENT REMINDERS (circle one) TEXT CALL EMAIL

INSURANCE INFORMATION

Subscriber _________________________ Insurance Carrier ______________________________

Subscriber DOB ____________________ ID# ________________________ Grp # ____________

Subscriber Employer ________________ Insurance Tel # __________________________________

WHO MAY WE THANK FOR REFERRING YOU? (circle one & list name or other referral source)

Friend/Relative Insurance Internet Mail Flyer Drive-By Other

_________________ _____________________

CONSENT TO PROCEED

I Authorize Sealy Kids Dentistry or assistants as they may designate to perform those procedures as may be deemed necessary or advisable to maintain my dental health or any minor or other individuals for which I have responsibility, including arrangement and/or administration of any sedative, restorative, palliative, therapeutic or surgical treatments. I understand that the administration of local anesthetic may cause an untoward reaction or side effect(s), which may include numbness, bruising and muscle soreness. I do voluntarily assume any and all risks, including the risk of substantial and serious harm, if any, which maybe associates with general preventative and operative treatment procedures in hopes of obtaining the potential desired result, which may or may not be achieved, for my benefit or my minor child or ward. I acknowledge that the nature and purpose of the foregoing procedures have been explained to me if necessary and I have been given the opportunity to ask questions. Further, I understand that meritless and frivolous claims for medical/dental malpractice have an adverse effect upon the cost and availability of healthcare and may result in irreparable harm to a healthcare provider. As additional consideration for professional care provided to me, I, the patient/guardian and or my representative agrees not to advance, directly, or indirectly, any false, meritless, and/or frivolous claim(s) of medical/dental malpractice case or cause of action be initiated or pursued. I and/or my representative agree to use expert witness(es) who practice primarily in the same specialty as Doctor. Furthermore, I agree that these expert witnesses will adhere to the guidelines and for code of conduct defined for expert witnesses by the American Dental Association. In further consideration for this Sealy Dental Doctors agree to the same stipulations.

____ ______________________

Signature of legal guardian or authorized agent Date

Patient's Medical History

Name ________________________________ DOB ________________

Please provide name and number of your child's pediatrician AND any other doctor(s) he/she is seeing:

____

Has your child ever been hospitalized or had a major operation? If YES, please describe below.

____

Is your child on a special diet? If YES, please describe. ____

LIST ALL CURRENT MEDICATIONS (Including over-the-counter)

____

ALLERGIES (Please select all that apply)

☐ Acrylics ☐ Codeine ☐ Iodine ☐ Local Anesthetics ☐ Penicillin ☐ Other ________________
☐ Aspirin ☐ Demerol ☐ Latex ☐ Metals ☐ Sulfa Drugs
☐ Barbiturates, Sedatives, Sleeping Meds ☐ Nitrous Oxide ☐ Valium

FOR FEMALES (Circle One) Are you, or could you be pregnant? Yes or No | Breast Feeding? Yes or No

DOES YOUR CHILD HAVE, OR HAD, ANY OF THE FOLLOWING?

☐ Abnormal/Prolonged Bleeding
☐ AIDS/HIV+
☐ ADD/ADHD
☐ Anaphylaxis
☐ Anemia
☐ Angina
☐ Artificial Heart Valve
☐ Artificial Joints
☐ Asthma
☐ Autism
☐ Blood Disease
☐ Blood Transfusion
☐ Bruise easily
☐ Cancer/Chemotherapy
☐ Chest Pain upon exertion
☐ Cold Sores/Fever Blisters
☐ Congenital Heart Defect, Disease, Disorder
☐ Diabetes
☐ Drug Addiction
☐ Eczema
☐ Emphysema
☐ Epilepsy
☐ Fainting/Seizures
☐ Frequent Cough
☐ Gastrointestinal Disorder
☐ Glaucoma
☐ Headaches/Migraines
☐ Heart Attack/Failure
☐ Heart Murmur
☐ Hemophilia
☐ High Blood Pressure
☐ High Cholesterol
☐ Hives or Rash
☐ Hypoglycemia
☐ Irregular Heartbeat
☐ Jaundice
☐ Kidney Problems
☐ Leukemia
☐ Liver Disease
☐ Low Blood Pressure
☐ Lung Disease
☐ Mental Health Disorder
☐ Mitral Valve Disorder
☐ Oral Sores/Ulcers
☐ Osteoporosis
☐ Parathyroid Disease
☐ Psychiatric Care
☐ Radiation Treatment
☐ Recurrent Infections
☐ Recent Weight Gain
☐ Recent Weight Loss
☐ Renal Dialysis
☐ Rheumatic Fever
☐ Rheumatoid Arthritis
☐ Scarlet Fever
☐ Shingles
☐ Sickle Cell Disease
☐ Sinus Trouble
☐ Spina Bifida
☐ Stomach/Intestinal Disease
☐ Stomach Ulcers
☐ STD
☐ Stroke
☐ Syndrome
☐ Thyroid Disease
☐ Tuberculosis
☐ Tumors or Growths

If you checked any of the above, please describe: ____

____

____

Any other serious illness, disease or disorder not listed above? ______________________________________

Parent/Guardian Initials: ________ Dr. Initials: ________

Patient's Medical History Cont.

Has your child ever had a bad dental experience? (circle one) YES or NO
If YES, please describe.

____

____

Has your child ever experienced any complications following dental treatment? (circle one) YES or NO
If YES, please describe.

____

____

Has your child ever experienced prolonged bleeding following dental treatment? (circle one) YES or NO
If YES, please describe.

____

____

Has your child ever experienced any pain or clicking in the jaw joint? YES or NO

Do you have family history of jaw surgery, missing teeth, or dental issues? (circle one) YES or NO
If YES, please describe.

____

____

Has your child had any dental trauma or injury to the jaw or teeth? (circle one) YES or NO
If YES, please describe.

____

____

I hereby certify that the above answers to the following question are accurate to the best of my knowledge. Since a change of medical condition or medications can affect dental treatment, I understand the importance of and agree to notify the dentist of any changes at any subsequent visit.

______________________________________ ____________________

Signature of legal guardian, or authorized agent Date

______________________________________ ____________________

Doctor Signature Date

SEALY KIDS DENTISTRY

Financial Policy
Thank you for choosing us as your dental care provider. It is very important to us that we establish the kind of relationship with you that provides the very best care in the most pleasant environment possible. To make financial arrangements for your treatment, we offer several flexible payment options. We accept cash, checks, all major credit cards, as well as extended payment plans upon credit approval. For unaccompanied minors, we ask that your make financial arrangements prior to the day of their appointment.

Dental Insurance
We are happy to accept assignment of insurance benefits from your insurance company. As a courtesy to you we will file your insurance and help you maximize your benefits. We will estimate your insurance coverage and your portion of the cost of the treatment, which is due at the date of service. Since this is an estimate only, you may have an additional balance due, or we may issue you a refund after we have received payment from your insurance carrier. It is important to note that the balance on your account is your responsibility regardless of your carrier's coverage.

Missed Appointments
Please help us serve you and all our patients best by keeping your scheduled appointment. If it is necessary to reschedule your appointment, please give us a 24-hour notice

Summary of Notice of Privacy Practices

Our Privacy Practices comply with Omnibus 2013

Sealy Dental Center keeps information of all your dental visits. We are required by law to maintain the privacy of your protected health information, and to provide you with notice of our legal duties and privacy practices with respect to your information upon request. You can also find the Notice on our website. This notice is a detailed explanation on how we may use your protected health information and your rights to inspect and amend your information. We are required by law, and by our own code of ethics, to keep your information private, and to follow the practices outlined in this Notice. Our Privacy Practices comply with Omnibus 2013 and are updated effective 09/23/2013.

* You have the right to refuse to sign this acknowledgment *

I have had full opportunity to read and consider the contents of this office's Notice of Privacy Practices. I understand I am giving my permission to use and disclose my protected health information to use in treatment, payment activities, and healthcare operations. I also understand that I have the right to revoke or modify this permission

Print Name ___________________________ Signature _______________________________ Date _______________________

For Office Use ONLY

We attempted to obtain written acknowledgment of our Notice of Privacy Practices, but acknowledgement could not be obtained:

☐ Individual refused to sign
☐ Communications barriers prohibited us from obtaining acknowledgement
☐ An emergency situation prevented us from obtaining acknowledgement
☐ Other reason (please specify)

____

____

____

____

____

2355 Hwy 36 South

Sealy, Texas 77474

979.987.6030

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided a copy of Sealy Kids Dentistry's Notice of Privacy Practices, which has an effective date of 9/22/2013, and which describes how my health information may be used and/or disclosed.

I understand that Sealy Dental Center has the right to change the Notice of Privacy Practices at any time, that I will be provided a copy of any updated version, and that I may contact you at any time to request a current Notice of Privacy Practices.

My signature below acknowledges that I have been provided with a copy of the Notice of Privacy Practices.

____ _______________________________

Signature of Patient, or Patient's Representative Date

____ _______________________________

Print Name Relationship to Patient

2355 Hwy 36 South

Sealy, Texas 77474

979.987.6030

Chart Photo Consent

I hereby give my consent to Sealy Kids Dentistry to obtain my minor child's photograph and keep in their file as part of the patient's record. I understand new photographs may be obtained through out their time with our office to keep the child's record current and up to date.

____________________________________ __________________________

Signature of parent, or legal guardian | Date

____________________________________ __________________________

Print Patients Name | Witness Signature

Social Media/Website Consent Form

I hereby consent to have my child's photo taken with staff members and/or by themselves, to be used on Sealy Kids Dentistry social media pages, in-office and/or Sealy Kids Dentistry's webpage. I understand that I, at any time, may request my child's photo be removed if I decide to change my mind at a later date.

Our current social media platforms and websites are listed below.
www.sealykidsdentistry.com
www.facebook.com/SealyKidsDentistry
www.instagram.com/sealykidsdds

Please leave this section blank if you wish to decline.

____________________________________ __________________________

Signature of parent, or legal guardian | Date

____________________________________ __________________________

Print Patients Name | Witness Signature