MCKINNEY PEDIATRIC DENTISTRY

Jon Schaack, DDS
5971 Virginia Pkwy, Ste 300, McKinney, TX 75071
Office: (972) 984-7890
www.McKinneyPD.com

Patient Information

Today's Date: _____

A.) Tell us about your Child:
Child's Name:
_____
Preferred Name: _____Male/Female
Birthday: _____Age: _____
Child's Home #:_____
Child's Home Address:
_____
City: _____ State: _____ Zip:_____

Child's School: _____
Grade: _____
Other Family Members Seen By Us: _____

B.) Mother's Information: Mom/Step-Mom /Guardian
Name: _____DOB: _____
Work # _____ Ext_____
Cell # _____ Home # _____
SS # _____ Employer: _____
E-mail: _____

C.) Father's Information: Father/Step-Father/Guardian
Name: _____DOB: _____
Work # _____ Ext _____
Cell # _____ Home # _____
SS # _____ Employer: _____
E-mail: _____

D.) Who is accompanying the child today?
Name: _____ Relation: _____
Do you have custody of this child? YES / NO
Parent's Marital Status: _____

E.) Person Responsible for Account.
Name: _____ Relation: _____
Billing Address: _____
City: _____State:_____ Zip: _____
Home #: _____ Work: _____
SS#: _____DL#_____

F.) Dental Insurance:
Insured Employer: _____
Insurance Name: _____
Insurance Address & Phone Number: _____
_____
Group #: _____Policy# _____
Policy Holder Name: _____
SS#: _____DOB: _____
Relationship to Patient: _____

G.) Referral Information: How did you hear about us?
_____ Website
_____ Referred by patient/parent. Who?_____
_____ Referred by dentist/Doctor. Who?_____
_____ Mailer
_____ Other (Please list below)
_____

Health History

YES NO Is your child in good health? Patient's Physicians Name: _____

Physician Phone # _____ Date of last physical exam: _____
Location of Physician Office: _____
YES NO Has your child ever had any health problems? If Yes, _____
YES NO Is your child allergic to anything? If Yes, _____
YES NO Were there any problems at birth? If Yes, _____
YES NO Has your child ever been hospitalized? Please give reason and dates: _____
_____
YES NO Is your child currently taking any medications? If Yes, please list and give reason: _____
_____

YES NO **For females only**: Due to x-rays taken and medications that we might prescribe, it is important to know if the patient is taking any contraceptives.

YES NO **For females only**: Is the patient pregnant, or is there a possibility that the patient is pregnant?

Health History (Continued)

Please **Check,** if your child has been treated for any of the following:

□ Heart disease	□ Bleeding/transfusions	□ Asthma	□ ADD/ADHD
□ Liver/GI disease	□ Anemia	□ Diabetes	□ AIDS/HIV
□ Kidney disease	□ Rheumatic fever	□ Hepatitis	□ Mental delays
□ Speech/hearing	□ Seizures	□ Cleft lip/palate	□ Physical delays
□ Cerebral Palsy	□ Congenital Birth Defects	□ Personality/social	□ Other problems
□ Cancer/tumors	□ Recurrent headaches	□ Frequent Infections	

Please elaborate on any items checked above: _____
_____

Do you consider your child to be: __ Advanced in the learning process __ Progressing normally __ Slow to learn

Was your child: __ Breast Fed __Bottle Fed At what age did they stop? _____

Reason for Today's Visit: _____

Dental History

YES NO Has your child ever been to the dentist? If yes, name of dentist_____
Date of last dental visit & radiographs_____

YES NO Has your child experienced any unfavorable reaction from previous dental care?
If yes, please explain: _____

YES NO Does your child suck a finger, thumb, or pacifier? If yes, please explain:
_____

Please **Check**, if your child is having problems with any of the following:

□ Cavities	□ Toothache	□ Teeth Sensitive
□ Trauma	□ Gum Infections	□ Color of teeth
□ Orthodontics	□ Jaw Sounds/pain	□ Other

Comments: _____

Fluoride History:

YES NO Is your home water supply Fluoridated?

YES NO Does your child use fluoride toothpaste?

YES NO Do you give your child any other form of fluoride?

Consent for Dental Treatment

I request and authorize Dr. Schaack to examine, clean, and provide dental treatment on my child's teeth. I further request and authorize the taking of dental x-rays considered necessary by Dr. Schaack to diagnose and/or treat my child's dental problem. I will allow photographs to be taken of my child or child's teeth for diagnostic or educational purposes. I understand that dental treatment for children includes efforts to guide their behavior by helping them to understand the treatment in terms appropriate for their age. Dr. Schaack will provide an environment likely to help children learn to cooperate during treatment by using praise, explanation and demonstration of procedures and instruments, and using variable voice tone. I will be responsible for any charges incurred on this child for dental treatment.

Signature: _____**Date**:_____

I give permission for the use of my child's name and picture for in-office promotions, our dental website and for dental advertising purposes (for example our No Cavities club).

_____
Parent's initial

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Parental Agreement

Parents are allowed to accompany their child into the treatment area during the initial examination. This gives you the opportunity to see our dental team in action and allows the doctors to discuss dental findings and treatment needs directly with you. **We do ask that if you accompany your child you assume the role of a silent observer. Your presence is greatly enhanced if you play a passive role.** If more than one person is speaking to the child they may become confused. Cooperation and trust must be established directly between the doctor or hygienist and your child. We also ask that siblings remain in the reception room or play area. There may be times when a child's experience is enhanced by a parent's absence. **After your child's first visit your child will come to the treatment area by themselves, unless specific arrangements have been made in advance.** This encourages autonomy and trust from the child. Children who are very apprehensive may look for an "escape" by going to their parents – this is why we ask that a parent wait in the reception room during treatment in order to facilitate a more direct line of communication between the child and the doctor. The following is a brief explanation of some of the methods we use to guide your child's behavior and provide a positive dental experience. Since each child is unique, no list can be complete and other methods may be explained as needed.

TELL, SHOW, DO
This is the most important tool for teaching your child. The child is told in simple terms what is going to be done. Then they are shown what is going to be done and then the procedure is performed.

IMAGERY
We tell children in simple terms what is going to be done. For example, a dental exam becomes "looking and counting your teeth". A dental prophylaxis and cleaning becomes "brush and tickle your teeth". We encourage you to use such terms when talking to your child about their dental experiences.

DISTRACTION
Sometimes it is necessary to distract your child from an unpleasant sensation by focusing his/her thoughts on something other than what is being done.

POSITIVE REINFORCEMENT
This is a technique used to reinforce good behavior by praising your child or providing a reward following a desired response in hopes of promoting continued good behavior.

VOICE CONTROL
Voice control is a controlled change of voice volume, tone or pace to influence and direct the child's behavior. This technique is used to establish a line of communication between our doctors and your child.
This agreement and these policies are in place to ensure that we can provide the best, most positive dental experience for your child. Please feel free to ask anyone in the office if you have a question or questions. Thank you for allowing us the opportunity to provide dental care for your child.

Signature_____ **Date**_____

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You may refuse to sign this acknowledgement

I, _____, have received a copy of the office's Notice of Privacy Practices. I also understand: The Legal Duty of McKinney Pediatric Dentistry, Uses and Disclosures of Health Information and My Patient Rights.

Please print parent or guardian's name.

Parent or guardian's signature.

Child or Children's names:

Today's date _____

For office use only

We have attempted to obtain written acknowledgement of the receipt of our Notice of Privacy Practices, however acknowledgement could not be obtained for the following reasons:

- **Parent/Guardian Refused to sign**
- **Communication barriers prohibited obtaining acknowledgement**
- **An emergency situation prevented acknowledgement**
- **Other_____**
  _____

If you have any questions or concerns, please let us know. Thank you,
Dr. Jon Schaack

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Child's Name: _____ **Parent's Name:** _____

Welcome to our office! We are pleased that you have chosen us to take care of your child's dental needs. To make our time together most efficient and enjoyable, we have listed several office policies.

Please read carefully:

Appointment Policies

1. **Your appointment**: *Be on time for your appointment.* If you are more than 10 minutes late, you risk cancellation of your appointment.
   BROKEN APPOINTMENT POLICY: If a scheduled appointment is missed, a late fee will be charged. The amount will depend on the type of appointment that was missed. If an appointment is missed for the second time without notice, a last chance will be given or inactivation of care (depending on the type of appointment missed). **Our voicemail is available 24 hours a day.**
   Bring your current insurance card to every appointment.

2. **Cancellations:** *A 48-hour notice must be given for cancellation of an appointment as well as confirmation of appointments.* Not having confirmation of set appointments may lead to the cancellation and rescheduling of the appointment as well as incurring a charge per the **Broken Appointment Policy** listed above. Please keep us up to date on all current phone numbers to help us in reaching you for confirmation. **Confirmations may be left on our voicemail at any time. Likewise, email confirmations can be sent to info@mckinneypd.com.**

Financial Policies

1. **Insurance:** As a **COURTESY** to our families with insurance, we will file your insurance claim. If an insurance company cannot confirm eligibility of benefits, you will be required to pay for all services at the time they are rendered. We have no control over your dental benefits and the amount an insurance company reimburses for a particular service. We are not told the exact amount of your out-of-pocket expense by the insurance company; therefore it is not possible to give you a completely accurate estimate. For these reasons, you are responsible for any non-covered services or deductibles.

2. **Statements:** We send monthly statements of all current balances so that you will be aware of what payments have been made to your account and what balance is still owed to the office. The first statement will be sent if there is remaining balance after insurance has made their payment. You will be given 30 days to make the payment or contact our office with any questions that you have. After 30 days, we will send another statement reminding you of the balance owed, and also informing you that your credit card on file will be charged for the amount owed unless specific arrangements are made with our office. All accounts with any balance due over 90 days will be referred to an outside collection agency.

Credit Card Number: _____Card Expiration: _____ Security Code: _____

I acknowledge that I am fully responsible for payment of any services or fees not covered by my insurance carrier and give permission to process payment on the card provided, per the **Financial Policy.** I have read and understand the above policies, including my obligations.

Signature/relationship: _____ Date:_____